IN THE UNITED STATES BANKRUPTCY COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
RICHMOND DIVISION

In re:	**Chapter 11**
CIRCUIT CITY STORES, INC., et al.,	**Case No. 08-35653-KRH**
Debtors.	**(Jointly Administered)**

CLAIMANT'S RESPONSE TO OBJECTION TO CLAIMS

NOW COMES the Claimant, **ROBERT E. MARSHALL**, by and through his attorney, **GEORGE J. COSENZA**, and presents this **RESPONSE TO OBJECTION TO CLAIMS** filed by the Debtor, **CIRCUIT CITY STORES, INC. LIQUIDATING TRUST.**

I. STATEMENT OF FACTS

Robert E. Marshall was a patron at the Circuit City store on Grand Central Avenue, in Vienna, Wood County, West Virginia on February 23, 2009 when he tripped over a display which was sticking out into the aisle. Mr. Marshall fell to the ground sustaining lacerations to his face and bruising and strain/sprain to his back and hips. Circuit City refused to render any aid to Mr. Marshall and Mr. Marshall was subsequently taken to the hospital by the EMT squad contacted by his daughter. As a result of Circuit City's negligence in making its store safe for patrons, Mr. Marshall suffered injuries as a result of the fall.

As a result of the above-referenced fall, Mr. Marshall received injuries and has incurred over $6,467.04 in special damages (attached hereto as Exhibit A) and seeks compensation for said damages.

Robert E. Marshall presented to Camden Clark Memorial Hospital on February 23, 2009, complaining of hip and back pain, and a 2.5cm laceration of the middle aspect of his left eyebrow and outer aspect of left eyebrow. He underwent a wound repair of the laceration to his

left eyebrow and was diagnosed with a sprain/strain injury for which he was treated at Mountain River Physical Therapy (attached hereto as Exhibit B).

Although Mr. Marshall has made some recovery given the nature of his injuries, he continues to suffer intermittent pain in his back and neck.

For the reasons set forth herein, it is the position of the Claimant that the Debtor's objection to claim should be **DENIED.**

George J. Cosenza, #833
GEORGE J. COSENZA, PLLC
515 Market Street - P.O. Box 4
Parkersburg, WV 26102
(304) 485-0990
Attorney for Claimant

CERTIFICATE OF SERVICE

The undersigned counsel for Claimant, **ROBERT E. MARSHALL,** hereby certifies that he served the **CLAIMANT'S RESPONSE TO OBJECTION TO CLAIMS**, upon the Debtor, **CIRCUIT CITY STORES, INC.,** by depositing a true copy thereof in the United States mail, postage prepaid, on this 19 day of June, 2012, addressed to the following:

Jeffrey N. Pomerantz, Esq.
Andrew W. Caine, Esq.
PACHULSKI STANG ZIEHL & JONES LLP
10100 Santa Monica Boulevard
Los Angeles, California 90067-4100

Lynn L. Tavenner, Esq.
Paula S. Beran, Esq.
TAVENNER & BERAN, PLC
20 North Eighth Street, 2nd Floor
Richmond, Virginia 23219

Robert J. Reinstein, Esq.
Pachulski Stang Ziehl & Jones LLP
780 Third Avenue, 36th Floor
New York, NY 10017

George J. Cosenza, #833
GEORGE J. COSENZA, PLLC
515 Market Street - P.O. Box 4
Parkersburg, WV 26102
(304) 485-0990
Attorney for Claimant

EXHIBIT A

ROBERT E. MARSHALL **DATE OF ACCIDENT: 2/23/09**

LIST OF SPECIAL DAMAGES
(as of 11/16/09)

Camden Clark Memorial Hospital		$1,127.54
(cost of medical records)		13.75
Mid-Ohio Valley Medical Group		$1,393.00
(cost of medical records)		22.75
Parkersburg Radiology		$2,509.00
(cost of medical records)		8.00
Johnson Chiropractic Center		$100.00
Mountain River Physical Therapy		$1,265.00
(cost of medical records)		28.00
	TOTAL	$6,467.04

EXHIBIT B

1	2	3a PAT. CNTL # / b. MED. REC. # / 5 FED TAX NO	4 TYPE OF BILL
CAMDEN CLARK MEM HOSP	CAMDEN CLARK MEM HOSP	34359224 1	0131
PO BOX 718	PO BOX 11345	00099473	
PARKERSBURG WV 26102	CHARLESTON WV25339	001W	
3044242111		311524546	

6 STATEMENT COVERS PERIOD FROM: 022309 THROUGH: 022309

8 PATIENT NAME a 80127599301
b MARSHALL, ROBERT E

9 PATIENT ADDRESS a 77 LITTLE ADDITION RD
b DAVISVILLE c WV d 26142

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
05081929	M			1	1	13	01	09												

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
03	022309													

38
MARSHALL, ROBERT E
77 LITTLE ADDITION RD

DAVISVILLE WV 26142

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	80	0	81	0		
b						
c						
d						

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0250	PHARMACY		022309	1	647		
0450	EMERGENCY ROOM	12011	022309	1	27100		
0450	EMERGENCY ROOM	9928325	022309	1	27100		
0636	DRUGS/DETAIL	90718	022309	1	8007		
0001	PAGE 1 OF 1	CREATION DATE	030209	TOTALS	62854	0	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
Advantage Freedom		Y	Y	14676	0	1699704254

57 OTHER PRV ID

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
MARSHALL, ROBERT E	18	80127599301		7604300440

63 TREATMENT AUTHORIZATION CODES

64 DOCUMENT CONTROL NUMBER

65 EMPLOYER NAME

66 DX 87342 V1588 9

67

68

69 ADMIT DX

70 PATIENT REASON DX 95909

71 PPS CODE

72 ECI

73

74 PRINCIPAL PROCEDURE CODE DATE

a. OTHER PROCEDURE CODE DATE

b. OTHER PROCEDURE CODE DATE

c. OTHER PROCEDURE CODE DATE

d. OTHER PROCEDURE CODE DATE

e. OTHER PROCEDURE CODE DATE

75

76 ATTENDING NPI 1841390341 QUAL
LAST BAKER FIRST DONALD

77 OPERATING NPI 1841390341 QUAL
LAST BAKER FIRST DONALD

78 OTHER NPI QUAL
LAST FIRST

79 OTHER NPI QUAL
LAST FIRST

80 REMARKS TRIPPED ON BROKEN S
CIRCUIT CITY IN PARKERSB

81CC a b c d

ADEN CLARK MEM HOSP
BOX 718
ARKERSBURG WV 26102
3044242111

2 CAMDEN CLARK MEM HOSP
PO BOX 11345
CHARLESTON WV25339

3a PAT. CNTL # 0134359950 1
b. MED. REC. # 00099473
5 FED. TAX NO 001W 311524546
6 STATEMENT COVERS PERIOD FROM 022309 THROUGH 022309
7
TYPE OF BILL 0131

8 PATIENT NAME a 80127599301
b MARSHALL, ROBERT E
9 PATIENT ADDRESS a 77 LITTLE ADDITION RD
b DAVISVILLE c WV d 26142 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
05081929	M				1		01	09												

(18–28 CONDITION CODES)

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
05	022309	A1	050829											

38
MARSHALL, ROBERT E
77 LITTLE ADDITION RD

DAVISVILLE WV 26142

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	80	0	81	0	A0	26105
b						
c						
d						

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0540	AMBULANCE MEDICAL TRANS	A0425QNSH	022309	3	3600		
0540	AMBULANCE MEDICAL TRANS	A0429QNSH	022309	1	46300		
0001	PAGE 1 OF 1	CREATION DATE	030209	TOTALS	49900	0	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
Advantage Freedom		Y	Y	32132	0

56 NPI 1699704254
57 OTHER PRV ID

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
MARSHALL, ROBERT E	18	80127599301		7604300440

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

95901
9

68
69 ADMIT DX
70 PATIENT REASON DX
71 PPS CODE
72 ECI
73

74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
75
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI 1790788545 QUAL
LAST BRAHAM FIRST JEFFREY
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

80 REMARKS CAUGHT FOOT ON SHEL
HOME

81CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 UB04L NUBC TFP24394485 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

CAMDEN-CLARK MEMORIAL HOSPITAL

800 Garfield Avenue
P.O. Box 718
Parkersburg, WV 26102
(304) 424-2214

Medical Record Services

08/21/09

ATTN: GEORGE J. COSENZA
GOLDENBERG,GOLDENBERG &STEALEY
200 STAR AVE, STE 222
PARKERSBURG, WV 26101

==========

RECORD COPY SERVICE CHARGES FEDERAL TAX #: 31-152-4546

Date of Request: 07/22/09

Patient: ROBERT E MARSHALL

Clerical Fees: $10.00

15 Pages @ $.25 each $3.75

_____ Radiographs @ $5.00 each $_____

TOTAL CHARGES $13.75

Request #: 131648 ** PLEASE INCLUDE REQUEST NUMBER ON YOUR CHECK **

==========

HOSPITAL USE ONLY

8351_____ 7011_____

7041_____ _____

MID OHIO VALLEY MEDICAL GROUP INC
PO BOX 1669

PARKERSBURG, WV 26102
304 485 4439

[CQFMA
Date
Time
User
Page

Inquiry

Lie

Patient #: 80652
Bill To #: 80652
DOB: 05/08/1929
Age: 80 Sex: M
SSN: [redacted]
H/Ph #: 304-422-2891
W/Ph #: 555-555-5555

Patient Name: ROBERT E MARSHALL
Resp Party: ROBERT E MARSHALL
Dr #: 32 JEFFERY T BRAHAM DO
RDr #: 32 JEFFERY T BRAHAM
Patient Type: 2 MEDICARE
Bill Cycle: 3 M-R
Credit Status: 0
Date Registered: 07/12/2000

Patient E-mail:
Responsible Party E-mail:

Balances	
0 - 30:	.00
31 - 60:	.00
61 - 90:	.00
91 - 120:	.00
121 - 150:	.00
151+ :	.00
Total Balance:	.00
- Pending:	.00
= Patient Balance:	.00
Budget Due:	.00
Non-budget Due:	.00
Total Due:	.00
Budget Balance:	.00
Budget Payment:	.00

Responsible Party Address:
77 LITTLE ADDITION RD

DAVISVILLE, WV 26142

Patient Address:
77 LITTLE ADDITION RD

DAVISVILLE, WV 26142

Last Transactions:

Charge:	03/03/2009	.00
Personal:	04/01/2009	10.00
Insurance:	03/12/2009	38.47

Location: 8 MID OHIO VALLEY
Diagnosis: VOID VOID FEE TICKET
Billing History: 03/16/2009 12/16/2007
09/16/2007 03/19/2006

Current Coverages

Cov#	Insurance Company	Insurance Plan	Subscriber
1	3567 ADVANTRA FREEDO		ROBERT E MARSHALL
	Subscriber ID: 80127599301	7604300440	
	Patient ID:		
3	9910 $10 COPAY		ROBERT E MARSHALL
	Subscriber ID: [redacted]		
	Patient ID:		

No details requested

Wed
Appt 5/22 8:45AM Belpre office

AMT 10-
PD BY: CASH ✓
CHECK #
CREDIT CARD
INITIALS A

MID OHIO VALLEY MEDICAL GROUP INC
PO BOX 1669

PARKERSBURG, WV 26102
304 485 4439

[CQFMAIN] Inquiry
Date 05/12/2009
Time 1:09p
User emrjm3
Page 1

Liz

Patient #: 80652
Bill To #: 80652
DOB: 05/08/1929
Age: 80 Sex: M
SSN: [redacted]
H/Ph #: 304-422-2891
W/Ph #: 555-555-5555

Patient Name: ROBERT E MARSHALL
Resp Party: ROBERT E MARSHALL
Dr #: 32 JEFFERY T BRAHAM DO
RDr #: 32 JEFFERY T BRAHAM
Patient Type: 2 MEDICARE
Bill Cycle: 3 M-R
Credit Status: 0
Date Registered: 07/12/2000

Patient E-mail:
Responsible Party E-mail:

Balances

0 - 30:	.00
31 - 60:	.00
61 - 90:	.00
91 - 120:	.00
121 - 150:	.00
151+ :	.00
Total Balance:	.00
- Pending:	.00
= Patient Balance:	.00
Budget Due:	.00
Non-budget Due:	.00
Total Due:	.00
Budget Balance:	.00
Budget Payment:	.00

Responsible Party Address:
77 LITTLE ADDITION RD

DAVISVILLE, WV 26142

Patient Address:
77 LITTLE ADDITION RD

DAVISVILLE, WV 26142

Last Transactions:

Charge:	03/03/2009	.00
Personal:	04/01/2009	10.00
Insurance:	03/12/2009	38.47

Location: 8 MID OHIO VALLEY
Diagnosis: VOID VOID FEE TICKET
Billing History: 03/16/2009 12/16/2007
09/16/2007 03/19/2006

Current Coverages

Cov#	Insurance Company	Insurance Plan	Subscriber
1	3567 ADVANTRA FREEDO		ROBERT E MARSHALL
	Subscriber ID: 80127599301	7604300440	
	Patient ID:		
3	9910 $10 COPAY		ROBERT E MARSHALL
	Subscriber ID: [redacted]		
	Patient ID:		

****
No details requested
****

Wed
>> Appt 5/22 8:45AM Before 9:00

AMT 10 -
PD BY: CASH ✓
CHECK #
CREDIT CARD
INITIALS

MID OHIO VALLEY MEDICAL GROUP INC
PO BOX 1669

PARKERSBURG, WV 26102
304 485 4439

[CQFMAIN] Inquiry
Date 07/24/2009
Time 2:57p
User emrsm
Page 1

Patient #: 80652
Bill To #: 80652
DOB: 05/08/1929
Age: 80 Sex: M
SSN: 233-44-6849
H/Ph #: 304-422-2891
W/Ph #: 555-555-5555

Patient Name: ROBERT E MARSHALL
Resp Party: ROBERT E MARSHALL
Dr #: 32 JEFFERY T BRAHAM DO
RDr #: 32 JEFFERY T BRAHAM
Patient Type: 2 MEDICARE
Bill Cycle: 3 M-R
Credit Status: 0
Date Registered: 07/12/2000

Patient E-mail:
Responsible Party E-mail:

Balances

0 - 30:	.00
31 - 60:	.00
61 - 90:	.00
91 - 120:	.00
121 - 150:	.00
151+ :	.00
Total Balance:	.00
- Pending:	.00
= Patient Balance:	.00
Budget Due:	.00
Non-budget Due:	.00
Total Due:	.00
Budget Balance:	.00
Budget Payment:	.00

Responsible Party Address:
77 LITTLE ADDITION RD

DAVISVILLE, WV 26142

Patient Address:
77 LITTLE ADDITION RD

DAVISVILLE, WV 26142

Last Transactions:

Charge:	06/22/2009	925.00
Personal:	07/02/2009	77.00
Insurance:	07/06/2009	253.46

Location: 9 MID OHIO VALLEY
Diagnosis: 724.2 LUMBAGO
Billing History: 06/14/2009 03/16/2009
12/16/2007 09/16/2007

Current Coverages

Cov#	Insurance Company	Insurance Plan	Subscriber
1	3567 ADVANTRA FREEDO		ROBERT E MARSHALL
	Subscriber ID: 80127599301	7604300440	
	Patient ID:		
3	9910 $10 COPAY		ROBERT E MARSHALL
	Subscriber ID: 233446849		
	Patient ID:		

Debit mode details

Patient#/Name: 80652 ROBERT E MARSHALL

Post Date	Debit#	Batch#/User	Dr# Name	Loc# Name	Orig Pend	Total
03/02/2009	1540118U	169/WH001	84 T CROOKSHANKS FN	8 MID OHIO	95.00	95.00

Cov#	Claim#	Ins Co# Name	Filed	Refiled	BA	PB	Status
1	15401181	3567 ADVANTRA FREEDOM MED	03/02/2009		Y	N	Paid

Dates of Service	Proc	Desc	Mod	Diag	PRT	Units	Unit Chg	Line Chg
03/02/2009-03/02/2009	99213	OFFICE/OUTPA		922.1	YYY	1.00	95.00	95.00

Post Date	Receipt#	Cov#	Transaction Type	Amount	Applied
03/12/2009	3986592U	1	2003567 PMT ADVANTRA FREEDOM	38.47	38.47-
03/12/2009	3986593U	1	4003567 W/O ADVANTRA FREEDOM	46.53	46.53-
03/12/2009	3986594U	1	9000101 Co-ins 10.00	.00	.00
04/01/2009	4022296U		1000102 #1016 CHECK PYMT	10.00	10.00-

	Paid	Write-off				
Primary:	38.47	46.53	Personal Paid:	10.00	Total Balance:	.00
Secondary:	.00	.00	Other Paid:	.00	Pending:	.00
Tertiary:	.00	.00	Pat Paid On Form:	.00	Patient Balance:	.00

MID OHIO VALLEY MEDICAL GROUP INC
PO BOX 1669

PARKERSBURG, WV 26102
304 485 4439

[CQFMAIN] Inquiry
Date 07/24/2009
Time 2:57p
User emrsm

Ins Total: 38.47 46.53

Patient#/Name: 80652 ROBERT E MARSHALL

Post Date	Debit#	Batch#/User	Dr# Name	Loc# Name	Orig Pend	Total
03/03/2009	1540064U	161/emrkdm	32 J BRAHAM DO	8 MID OHIO	.00	.00

Dates of Service	Proc	Desc	Mod Diag	PRT	Units	Unit Chg	Line Chg
03/02/2009-03/02/2009		VOID FEE TIC		NNN	1.00	.00	.00

	Paid	Write-off				
Primary:	.00	.00	Personal Paid:	.00	Total Balance:	.00
Secondary:	.00	.00	Other Paid:	.00	Pending:	.00
Tertiary:	.00	.00	Pat Paid On Form:	.00	Patient Balance:	.00
Ins Total:	.00	.00				

Patient#/Name: 80652 ROBERT E MARSHALL

Post Date	Debit#	Batch#/User	Dr# Name	Loc# Name	Orig Pend	Total
05/14/2009	1595812U	168/KDM001	323 J BRAHAM DO	8 MID OHIO	67.00	67.00

Cov#	Claim#	Ins Co#	Name	Filed	Refiled	BA	PB	Status
1	15958121	3567	ADVANTRA FREEDOM MED	05/14/2009		Y	N	Paid

Dates of Service	Proc	Desc	Mod Diag	PRT	Units	Unit Chg	Line Chg
05/12/2009-05/12/2009	90718	TETANUS AND	959.09	YYY	1.00	32.00	32.00
05/12/2009-05/12/2009	90471	IMMUNIZATION	959.09	YYY	1.00	35.00	35.00

Post Date	Receipt#	Cov#	Transaction Type	Amount	Applied
06/01/2009	4144286U	1	2003567 DENIED ADVANTRA FREEDOM	.00	.00
07/02/2009	4206165U		1000102 1046# CHECK PYMT	77.00	67.00-

	Paid	Write-off				
Primary:	.00	.00	Personal Paid:	67.00	Total Balance:	.00
Secondary:	.00	.00	Other Paid:	.00	Pending:	.00
Tertiary:	.00	.00	Pat Paid On Form:	.00	Patient Balance:	.00
Ins Total:	.00	.00				

Patient#/Name: 80652 ROBERT E MARSHALL

Post Date	Debit#	Batch#/User	Dr# Name	Loc# Name	Orig Pend	Total
05/19/2009	1601268U	168/KDM001	50 L UNDERWOOD FNPB	8 MID OHIO	95.00	95.00

Cov#	Claim#	Ins Co#	Name	Filed	Refiled	BA	PB	Status
1	16012681	3567	ADVANTRA FREEDOM MED	05/19/2009		Y	N	Paid

Dates of Service	Proc	Desc	Mod Diag	PRT	Units	Unit Chg	Line Chg
05/12/2009-05/12/2009	99213	OFFICE/OUTPA	726.5	YYY	1.00	95.00	95.00
05/12/2009-05/12/2009	DX	ADDITIONAL D	959.09	YYY	1.00	.00	.00

Post Date	Receipt#	Cov#	Transaction Type	Amount	Applied
05/19/2009	4121546U		1000001 CASH AT APPT	10.00	10.00-
06/04/2009	4154174U	1	2003567 PMT ADVANTRA FREEDOM	38.47	38.47-
06/04/2009	4154175U	1	4003567 W/O ADVANTRA FREEDOM	46.53	46.53-
06/04/2009	4154176U	1	9000101 Co-ins 10.00	.00	.00

	Paid	Write-off				
Primary:	38.47	46.53	Personal Paid:	10.00	Total Balance:	.00
Secondary:	.00	.00	Other Paid:	.00	Pending:	.00
Tertiary:	.00	.00	Pat Paid On Form:	.00	Patient Balance:	.00
Ins Total:	38.47	46.53				

Patient#/Name: 80652 ROBERT E MARSHALL

Post Date	Debit#	Batch#/User	Dr# Name	Loc# Name	Orig Pend	Total
05/27/2009	1471139U	169/WH001	32 J BRAHAM DO	9 MID OHIO	95.00	95.00

Cov#	Claim#	Ins Co#	Name	Filed	Refiled	BA	PB	Status
1	14711391	3567	ADVANTRA FREEDOM MED	05/28/2009		Y	N	Paid

Dates of Service	Proc	Desc	Mod Diag	PRT	Units	Unit Chg	Line Chg
05/27/2009-05/27/2009	99213	OFFICE/OUTPA	250.00	YYY	1.00	95.00	95.00
05/27/2009-05/27/2009	DX	ADDITIONAL D	272.2	YYY	1.00	.00	.00
05/27/2009-05/27/2009	DX	ADDITIONAL D	401.1	YYY	1.00	.00	.00

Post Date	Receipt#	Cov#	Transaction Type	Amount	Applied
06/09/2009	4159697U	1	2003567 PMT ADVANTRA FREEDOM	49.59	49.59-
06/09/2009	4159698U	1	4003567 W/O ADVANTRA FREEDOM	35.41	35.41-
06/09/2009	4159699U	1	9000101 Co-ins 10.00	.00	.00
07/02/2009	4206165U		1000102 1046# CHECK PYMT	77.00	10.00-

Paid Write-off

MID OHIO VALLEY MEDICAL GROUP INC
PO BOX 1669

PARKERSBURG, WV 26102
304 485 4439

[CQFMAIN] Inquiry
Date 07/24/2009
Time 2:57p
User emrsm

Primary:	49.59	35.41	Personal Paid:	10.00	Total Balance:	.00
Secondary:	.00	.00	Other Paid:	.00	Pending:	.00
Tertiary:	.00	.00	Pat Paid On Form:	.00	Patient Balance:	.00
Ins Total:	49.59	35.41				

Patient#/Name: 80652 ROBERT E MARSHALL

Post Date	Debit#	Batch#/User	Dr# Name	Loc# Name	Orig Pend	Total
05/28/2009	1608014U	0/KDM001	32 J BRAHAM DO	8 MID OHIO	116.00	116.00

Cov#	Claim#	Ins Co#	Name	Filed	Refiled	BA	PB	Status
1	16080141	3567	ADVANTRA FREEDOM MED	05/28/2009		Y	N	Paid

Dates of Service	Proc	Desc	Mod Diag	PRT	Units	Unit Chg	Line Chg
05/27/2009-05/27/2009	80061	LIPID PROFIL	272.2	YYY	1.00	51.00	51.00
05/27/2009-05/27/2009	80053	METABOLIC PA	250.00	YYY	1.00	30.00	30.00
05/27/2009-05/27/2009	83036	GLYCOSYLATED	250.00	YYY	1.00	35.00	35.00
05/27/2009-05/27/2009	DX	ADDITIONAL D	401.1	YYY	1.00	.00	.00

Post Date	Receipt#	Cov#	Transaction Type	Amount	Applied
06/09/2009	4159701U	1	2003567 PMT ADVANTRA FREEDOM	29.61	29.61-
06/09/2009	4159702U	1	4003567 W/O ADVANTRA FREEDOM	86.39	86.39-

	Paid	Write-off				
Primary:	29.61	86.39	Personal Paid:	.00	Total Balance:	.00
Secondary:	.00	.00	Other Paid:	.00	Pending:	.00
Tertiary:	.00	.00	Pat Paid On Form:	.00	Patient Balance:	.00
Ins Total:	29.61	86.39				

Patient#/Name: 80652 ROBERT E MARSHALL

Post Date	Debit#	Batch#/User	Dr# Name	Loc# Name	Orig Pend	Total
05/28/2009	1608015U	168/KDM001	32 J BRAHAM DO	9 MID OHIO	15.00	15.00

Cov#	Claim#	Ins Co#	Name	Filed	Refiled	BA	PB	Status
1	16080151	3567	ADVANTRA FREEDOM MED	05/28/2009		Y	N	Paid

Dates of Service	Proc	Desc	Mod Diag	PRT	Units	Unit Chg	Line Chg
05/27/2009-05/27/2009	36415	DRAWING BLOO	401.1	YYY	1.00	15.00	15.00

Post Date	Receipt#	Cov#	Transaction Type	Amount	Applied
06/09/2009	4159704U	1	2003567 PMT ADVANTRA FREEDOM	3.00	3.00-
06/09/2009	4159705U	1	4003567 W/O ADVANTRA FREEDOM	12.00	12.00-

	Paid	Write-off				
Primary:	3.00	12.00	Personal Paid:	.00	Total Balance:	.00
Secondary:	.00	.00	Other Paid:	.00	Pending:	.00
Tertiary:	.00	.00	Pat Paid On Form:	.00	Patient Balance:	.00
Ins Total:	3.00	12.00				

Patient#/Name: 80652 ROBERT E MARSHALL

Post Date	Debit#	Batch#/User	Dr# Name	Loc# Name	Orig Pend	Total
06/12/2009	1613113U	5022/emrdr	32 J BRAHAM DO	9 MID OHIO	.00	.00

Dates of Service	Proc	Desc	Mod Diag	PRT	Units	Unit Chg	Line Chg
06/11/2009-06/11/2009		VOID FEE TIC		NNN	1.00	.00	.00

	Paid	Write-off				
Primary:	.00	.00	Personal Paid:	.00	Total Balance:	.00
Secondary:	.00	.00	Other Paid:	.00	Pending:	.00
Tertiary:	.00	.00	Pat Paid On Form:	.00	Patient Balance:	.00
Ins Total:	.00	.00				

Patient#/Name: 80652 ROBERT E MARSHALL

Post Date	Debit#	Batch#/User	Dr# Name	Loc# Name	Orig Pend	Total
06/22/2009	1620333U	9944/emrth	32 J BRAHAM DO	9 MID OHIO	925.00	925.00

Cov#	Claim#	Ins Co#	Name	Filed	Refiled	BA	PB	Status
1	16203331	3567	ADVANTRA FREEDOM MED	06/22/2009		Y	N	Paid

Dates of Service	Proc	Desc	Mod Diag	PRT	Units	Unit Chg	Line Chg
06/19/2009-06/19/2009	72131	CT LUMBAR SP	111 724.2	YYY	1.00	565.00	565.00
06/19/2009-06/19/2009	76377	REFORMAT CT	111 724.2	YYY	1.00	360.00	360.00

Post Date	Receipt#	Cov#	Transaction Type	Amount	Applied
07/06/2009	4210268U	1	2003567 PMT ADVANTRA FREEDOM	253.46	253.46-
07/06/2009	4210269U	1	4003567 W/O ADVANTRA FREEDOM	671.54	671.54-

	Paid	Write-off				
Primary:	253.46	671.54	Personal Paid:	.00	Total Balance:	.00

MID OHIO VALLEY MEDICAL GROUP INC
PO BOX 1669

PARKERSBURG, WV 26102
304 485 4439

[CQFMAIN] Inquiry
Date 07/24/2009
Time 2:57p
User emrsm
Page 4

Secondary:	.00	.00	Other Paid:	.00	Pending: .00
Tertiary:	.00	.00	Pat Paid On Form:	.00	Patient Balance: .00
Ins Total:	253.46	671.54			

MID-OHIO VALLEY MEDICAL GROUP

FAX COVER SHEET

Please deliver transmitted pages

TO: George Cosenza

FROM: Dr Braham

Mid Ohio Valley Medical Group, Inc.
800 Grand Central Mall Ste 4
Vienna, WV 26105

DATE: JUL 24 2009

TOTAL NUMBER OF PAGES: 1 (Including this Fax Cover Sheet)

IF ALL PAGES ARE NOT RECEIVED, OR IF YOU NEED CLARIFICATION, PLEASE CALL Sagady-S at 304-435-4439 ext 230 as soon as possible.

MESSAGE/COMMENTS:

RE: Robert Marshall 5-8-29 233446849

medical records cost $22.75

#pgs 17

PAID

TAX ID# 55-0771901

Mid Ohio Valley Medical Group, Inc.
800 Grand Central Mall, Suite 4
Vienna, WV 26105

P.O. Box 1669 • Parkersburg, WV 26102 • (304) 485-3300 • Fax: (304) 485-3317

09/24/09 PATIENT PROCEDURE HISTORY BY DT SERVICE

PARKERSBURG RADIOLOGY

Accounts 44812 - 44812 All Dates

File : a:prohist.dat

Acct	Date	Dep #	Name	Dr #	Procedure		Diag	Units	Charge
44812	MARSHALL,ROBERT								
	12/10/99	0	MARSHALL,ROBERT	3	74270	COLON; BARIUM ENEMA	569.3	1.00	84.00
	08/24/01	0	MARSHALL,ROBERT	4	74160	CT, ABDOMEN WITH CON	789.09	1.00	180.00
	08/24/01	0	MARSHALL,ROBERT	4	72193	CT,PELVIS WITH CONTR	789.07	1.00	25.00
	05/02/03	0	MARSHALL,ROBERT	3	73520,1	HIPS BILATERAL W/1 V	719.45	1.00	83.00
	10/09/04	0	MARSHALL,ROBERT	10	71010	CHEST 1 VIEW POSTERO	518.3	1.00	21.00
	10/09/04	0	MARSHALL,ROBERT	10	71260	CT,THORAX WITH CONTR	518.3	1.00	180.00
	03/07/05	0	MARSHALL,ROBERT	5	74170	CT, ABDOMEN WITH/WO	789.09	1.00	206.00
	03/07/05	0	MARSHALL,ROBERT	5	72194	CT,PELVIS WITH & W/O	562.11	1.00	206.00
	07/31/05	0	MARSHALL,ROBERT	2	70450	CT HEAD W/O CONTRAST	435.9	1.00	142.00
	08/01/05	0	MARSHALL,ROBERT	11	70551	MRI BRAIN W/O CONTRA	780.4	1.00	160.00
	08/01/05	0	MARSHALL,ROBERT	11	70544	MRA HEAD W/O CONTRAS	780.4	1.00	160.00
	02/09/06	0	MARSHALL,ROBERT	11	93880	ULTRASOUND CAROTID I	785.9	1.00	109.00
	08/14/06	0	MARSHALL,ROBERT	5	93880	ULTRASOUND CAROTID I	785.9	1.00	109.00
	08/30/06	0	MARSHALL,ROBERT	5	70548	MRA, NECK WITH CONTR	433.10	1.00	191.00
	03/02/09	0	MARSHALL,ROBERT	11	71100,1	RIBS UNILATERAL 2 VI	518.89	1.00	89.00
	05/12/09	0	MARSHALL,ROBERT	2	73550,1	FEMUR 2 VIEWS	729.5	1.00	77.00
	05/12/09	0	MARSHALL,ROBERT	2	73510,1	HIP TWO VIEWS	719.45	1.00	103.00
	05/28/09	0	MARSHALL,ROBERT	4	72100,1	LUMBOSACRAL SPINE	722.93	1.00	108.00
	06/19/09	0	MARSHALL,ROBERT	2	72131	CT,LUMBAR SP. W/O CO	737.20	1.00	161.00
	06/19/09	0	MARSHALL,ROBERT	2	76377	3D RECONSTRUCT INDEP	737.20	1.00	115.00
						TOTAL FOR ACCOUNT 44812		20.00	2509.00

CORPORATION

1107 Garfield Ave. * P. O. Box 779 * Parkersburg, WV 26102 * Phone: 304.422.1133 * Fax 304.422.2499

SEPTEMBER 24, 2009

GEORGE J COZENZA, PLLC
515 MARKET STREET
P.O. BOX 4
PARKERSBURG, WV 26102

ACCOUNT# 44812
PATIENT: ROBERT E MARSHALL

RE: CHARGE FOR COPIES PROVIDED AS PER YOUR REQUEST

We are enclosing herewith the copies of documents as per your request. Also, to offset our costs to provide this service to you we request that you reimburse us in the amount of:

$8.00

Please make your payment payable to: MFC Corporation
And mail it to: PO Box 779
Parkersburg, WV 26102

Should you need to contact us again concerning these documents, Please direct such inquiry to my attention.

Thank you,

Stephanie Holland
Parkersburg Radiology
304-422-6573 telephone
304-422-2499 fax

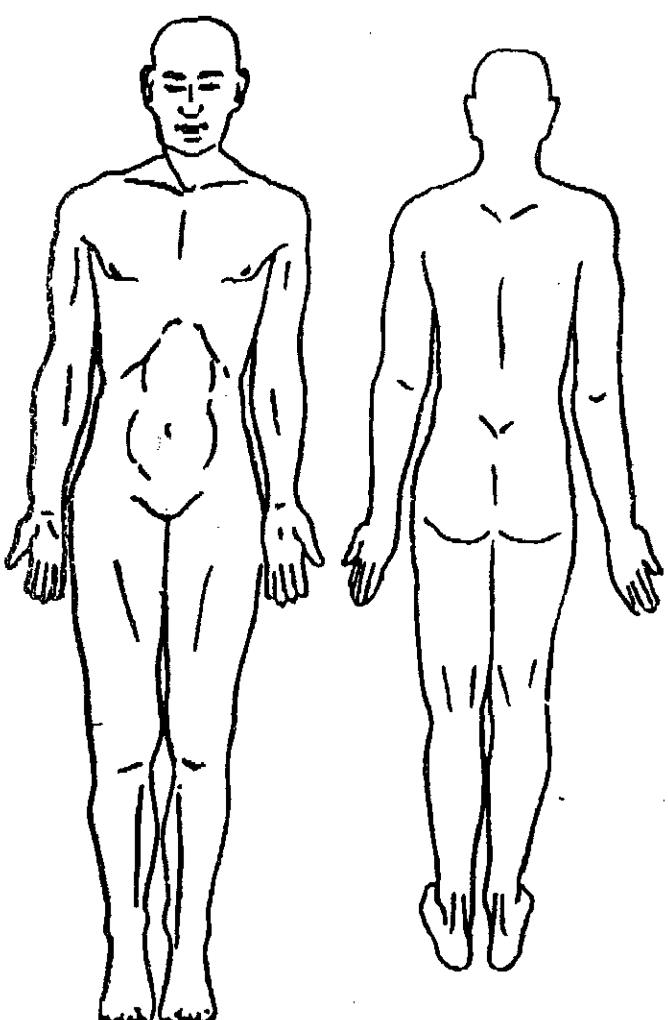
550522573 tax identification number

Please return the second page along with your payment to the aforementioned address.

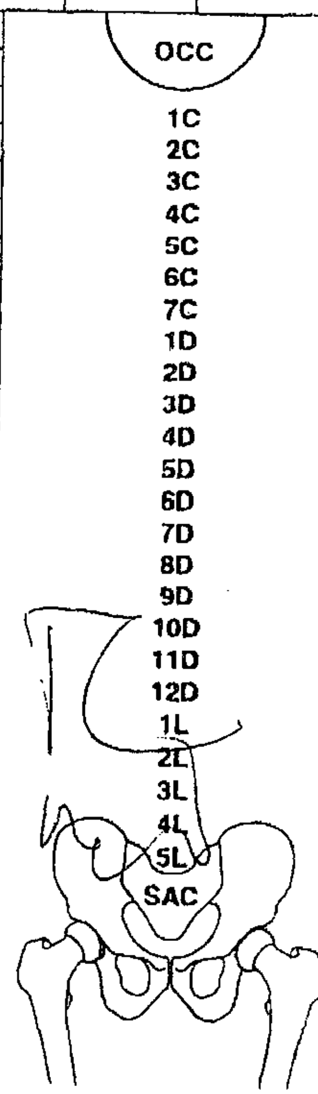
Robert Marshall **PATIENT RECORD** "duplicate" **ACCOUNT**

Date	Spinal Manipulation	Therapy	Treatment	Chg.	Paid	Bal.
MAY 1?	☐ Cervical ☐ Thoracic ☐ Lumbar	☐ Heat ☐ Ice ☐ LV ☐		25	mc	25
MAY 2 0 2002	☐ Cervical ☐ Thoracic ☐ Lumbar	☐ Heat ☐ Ice ☐ LV ☐		25	mc	50
7/9/02	☐ Cervical ☐ Thoracic ☐ Lumbar	☐ Heat ☐ Ice ☐ LV ☐	mc pd 5/15/02 - 5/20/02	(50)	38.20	Ø
8 28 02	☐ Cervical ☐ Thoracic ☐ Lumbar	☐ Heat ☐ Ice ☐ LV ☐	ins pd. 5/15/02 - 5/20/02		9.56	Ø
FEB 1 ?	☐ Cervical ☐ Thoracic ☐ Lumbar	☐ Heat ☐ Ice ☐ LV ☐		15	15	
APR 1 7 2009	☐ Cervical ☐ Thoracic ☐ Lumbar	☐ Heat ☐ Ice ☐ LV ☐		35	20	15
5/6/09	☐ Cervical ☐ Thoracic ☐ Lumbar	☐ Heat ☐ Ice ☐ LV ☐	billed 4/17/09			15
6/8/09	☐ Cervical ☐ Thoracic ☐ Lumbar	☐ Heat ☐ Ice ☐ LV ☐	ins pd. 4/17/09	(35)	32.28	-?
6/8/9	☐ Cervical ☐ Thoracic ☐ Lumbar	☐ Heat ☐ Ice ☐ LV ☐	pt refund		20	0
	☐ Cervical ☐ Thoracic ☐ Lumbar	☐ Heat ☐ Ice ☐ LV ☐				
	☐ Cervical ☐ Thoracic ☐ Lumbar	☐ Heat ☐ Ice ☐ LV ☐				
	☐ Cervical ☐ Thoracic ☐ Lumbar	☐ Heat ☐ Ice ☐ LV ☐				
	☐ Cervical ☐ Thoracic ☐ Lumbar	☐ Heat ☐ Ice ☐ LV ☐				
	☐ Cervical ☐ Thoracic ☐ Lumbar	☐ Heat ☐ Ice ☐ LV ☐				
	☐ Cervical ☐ Thoracic ☐ Lumbar	☐ Heat ☐ Ice ☐ LV ☐				
	☐ Cervical ☐ Thoracic ☐ Lumbar	☐ Heat ☐ Ice ☐ LV ☐				
	☐ Cervical ☐ Thoracic ☐ Lumbar	☐ Heat ☐ Ice ☐ LV ☐				
	☐ Cervical ☐ Thoracic ☐ Lumbar	☐ Heat ☐ Ice ☐ LV ☐				
	☐ Cervical ☐ Thoracic ☐ Lumbar	☐ Heat ☐ Ice ☐ LV ☐				
	☐ Cervical ☐ Thoracic ☐ Lumbar	☐ Heat ☐ Ice ☐ LV ☐				
	☐ Cervical ☐ Thoracic ☐ Lumbar	☐ Heat ☐ Ice ☐ LV ☐				

MARK AREA OF PAIN
(by patient)



Date	Subsequent Complaints
	X-rays @ CEM H
	will call c date
	MC # 233-44-6849A.
	xe - 8/24/01
* 1/03	ent. into new MC program



OCC - Occiput
C - Cervical Vertebrae
D - Dorsal Vertebrae
L - Lumbar Vertebrae
SAC - Sacrum

SPINAL ANALYSIS

Patient Statement Inquiry

Patient : 10266 - Marshall,Robert

05-19-2009	97001	PT Eval	1.00	100.00
	97014	Electrical Stim- Unattended	1.00	25.00
05-20-2009	97014	E-stim Unat	1.00	25.00
	97140	Manual Therapy	1.00	50.00
	97110	Therapeutic Exercises	2.00	80.00
05-22-2009	97014	E-stim Unat	1.00	25.00
	97110	Therapeutic Exercises	2.00	80.00
05-27-2009	97014	E-stim Unat	1.00	25.00
	97110	Therapeutic Exercises	2.00	80.00
05-29-2009	97110	Ther. Ex.	2.00	80.00
05-29-2009	Payment	ADVANTRA FREEDOM paid 165.27 for DOS 05/20/09 - 05/20/09 via check # 14465365, Batch #		-165.27
05-29-2009	Discount	Discount of $114.73 for DOS 05/20/09 - 05/20/09.		-114.73
06-02-2009	97140	Manual.Ther	1.00	50.00
	97110	Therapeutic Exercises	3.00	120.00
06-04-2009	97140	Manual.Ther	1.00	50.00
	97110	Therapeutic Exercises	3.00	120.00
06-04-2009	Payment	ADVANTRA FREEDOM paid 63.76 for DOS 05/27/09 - 05/27/09 via check # 14466432, Batch # 06042009era.		-63.76
06-04-2009	Payment	ADVANTRA FREEDOM paid 63.76 for DOS 05/22/09 - 05/22/09 via check # 14465892, Batch # 06042009era.		-63.76
06-04-2009	Discount	Discount of $41.24 for DOS 05/27/09 - 05/27/09.		-41.24
06-04-2009	Discount	Discount of $41.24 for DOS 05/22/09 - 05/22/09.		-41.24
06-08-2009	Payment	ADVANTRA FREEDOM paid 52.90 for DOS 05/29/09 - 05/29/09 via check # 14467023, Batch # 06082009era.		-52.90
06-08-2009	Discount	Discount of $27.10 for DOS 05/29/09 - 05/29/09.		-27.10
06-09-2009	97140	Manual.Ther	1.00	50.00
	97110	Therapeutic Exercises	3.00	120.00
06-11-2009	Payment	ADVANTRA FREEDOM paid 103.70 for DOS 06/02/09 - 06/02/09 via check # 14467641, Batch #		-103.70
06-11-2009	Discount	Discount of $66.30 for DOS 06/02/09 - 06/02/09.		-66.30
06-12-2009	97002.59	PT Re-Eval Mod.	1.00	65.00
	97110	Therapeutic Exercises	3.00	120.00
06-15-2009	Payment	ADVANTRA FREEDOM paid 103.70 for DOS 06/04/09 - 06/04/09 via check # 14468240, Batch #		-103.70
06-15-2009	Discount	Discount of $66.30 for DOS 06/04/09 - 06/04/09.		-66.30
06-19-2009	Payment	ADVANTRA FREEDOM paid 103.70 for DOS 06/09/09 - 06/09/09 via check # 14468837, Batch #		-103.70
06-19-2009	Discount	Discount of $66.30 for DOS 06/09/09 - 06/09/09.		-66.30
06-23-2009	Payment	ADVANTRA FREEDOM paid 114.49 for DOS 06/12/09 - 06/12/09 via check # 14469422, Batch #		-114.49
06-23-2009	Discount	Discount of $70.51 for DOS 06/12/09 - 06/12/09.		-70.51
		Total Charges on Account:		**1265.00**
		Total Payments on Account:		**-771.28**

Patient Statement Inquiry

Patient : 10266 - Marshall,Robert

		Total Discounts on Account:		-493.72
		Total Account Adjustments:		0.00
		Total Account Charge Reversals:		0.00
		Account Balance Due:		0.00

MOUNTAIN RIVER PHYSICAL THERAPY

1212 Garfield Avenue, Suite 200
Parkersburg, WV 26101
Phone: 304-865-6778
Fax: 304-865-7400

August 4, 2009

George J. Cosenza, PLLC
515 Market Street
P O Box 4
Parkersburg, WV 26102

RE: Robert E. Marshall
DOB: 5-8-29
SSN: 273-44-6849

PAID

Dear George:

We have received your request for copies of Robert's medical records. In accordance with WV Code 16-29-2 our fee for this service is $10.00 plus $0.75 per page.

# of pages: 24
Total Cost: $ 28.00

We will be happy to forward a copy of her/his records once we receive payment.

Sincerely,

Janet Beeson

Janet Beeson
Office Assistant
Mountain River Physical Therapy
FEIN# 550764678

CAMDEN-CLARK MEMORIAL HOSPITAL
Parkersburg, WV 26102

REGISTRATION FORM

PATIENT NAME/ADDRESS	ACCOUNT NO.	ROOM/BED	TYPE	LOCATION/SERVICE	UNIT NO./MR#
MARSHALL,ROBERT E 77 LITTLE ADDITION RD DAVISVILLE,WV 26142 PHONE: 304-422-2891 SOCIAL SECURITY NO.: 233-44-6849 EMPLOYER: RETIRED	34359224		ER	ER	00099473

DATE OF BIRTH	AGE	SEX	MAR. STAT.	RELIGION	RACE
05/08/29	79	M	U		

PERSON TO NOTIFY/ADDRESS | RELATIONSHIP:

GUARANTOR/ADDRESS
MARSHALL,ROBERT E
77 LITTLE ADDITION RD
DAVISVILLE,WV 26142
PHONE: 304-422-2891
RELATIONSHIP: SAME AS PATIENT (SELF)
GUAR. EMPLOYER: RETIRED

HOME PHONE: WORK PHONE:

NEXT OF KIN/ADDRESS | RELATIONSHIP:

FINANCIAL CLASS: MC

HOME PHONE: WORK PHONE:

INSURANCE NAME	POLICY NUMBER	GROUP NUMBER	SUBSCRIBER/INSURED NAME
ADVANTRA FREEDOM - MEDICARE	80127599301	7604300440	MARSHALL,ROBERT E

ACCIDENT INFORMATION | REASON FOR VISIT
FALL INJURY

ACCIDENT DATE/TIME	COMMENTS PER PT	HEIGHT/WEIGHT	ARRIVAL MODE	USER
/		5/7 210	COMM AMB	CR--CLH

ADMIT DATE/TIME	ADMITTING PHYSICIAN	ATTENDING PHYSICIAN	PRIMARY CARE PHYSICIAN
02/23/09 1136		BRAHAM,JEFFREY, DO.	

HOSP.DAYS	H OMI SNF ICF HH DIED AUT	SURGEON:	CONSULT:	DISCH DATE/TIME
		ANESTHESIOLOGIST:	CONSULT:	

ADMITTING DIAGNOSIS

DIAGNOSIS AND PROCEDURE CODE

PRINCIPAL DIAGNOSIS

SECONDARY DIAGNOSIS

PROCEDURES

I certify that the narrative descriptions of the principal and secondary diagnoses and the major procedures performed are accurate and complete to the best of my knowledge.

MEDICAL RECORD SUMMARY SHEET

Attending Physician

Date

CAMDEN-CLARK MEMORIAL HOSPITAL
PARKERSBURG, WEST VIRGINIA 26101

CONSENT TO DIAGNOSIS AND/OR TREATMENT

I, MARSHALL,ROBERT E;34359224 hereby authorize the staff of CAMDEN-CLARK MEMORIAL HOSPITAL to perform any and/or all procedures and treatments ordered in the diagnosis and treatment of my disorder. In the event any of my physicians deem it necessary that I be administered an anesthetic, other than a local anesthetic, or that I undergo a surgical or other hazardous diagnostic or therapeutic procedure, a separate consent will be required. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of the examination, diagnostic procedure or treatment. In accordance with the policy of the Hospital, CAMDEN-CLARK MEMORIAL HOSPTIAL, is hereby authorized to furnish such professional information from my medical record to any physician and/or health care facility engaged in my subsequent medical care. *INITIALS* REM

STUDENT EDUCATION

Camden-Clark Memorial Hospital maintains educational affiliations with area and regional schools for the purpose of *providing clinical experiences to their students. I understand and agree that students may participate in or be present* at various times during my care at Camden-Clark Memorial Hospital. *INITIALS* RM

PAYMENT GUARANTEE/ASSIGNMENT OF INSURANCE BENEFITS/AUTHORIZATION TO BILL THIRD PARTY PAYORS

I, hereby authorize direct payment to Camden-Clark Memorial Hospital the benefits herein specified and otherwise payable to me. I also authorize direct payment to the physicians responsible for my care for charges for their services. I understand I am financially responsible to the Hospital and physicians for all charges.
I further authorize the release of medical information to any third party payor or agent thereof.
Where applicable, I authorize the Hospital to apply for payment under Title XVIII of the Social Security Act. I authorize release of any information given by me in applying for such payment and certify that such information is true and correct. I request that payment of authorized benefits be made in my behalf. I understand I am responsible for any applicable health insurance deductibles and coinsurance. *INITIALS* RM

RELEASE OF LIABILITY FOR PERSONAL PROPERTY

I have been told that I should send all valuables and money home. If I do not, I hereby agree and acknowledge that I alone will be solely responsible for the safekeeping of personal property including, but not limited to, cash, visual aids, hearing aids, dentures and jewelry which I have by choice retained in my possession while I am a patient in Camden-Clark Memorial Hospital. I do hereby release Camden-Clark Memorial Hospital, its agents and employees from any and all liability for loss, theft or damage to such property. *INITIALS* RM

PHYSICIAN AND ALLIED HEALTH SERVICES

The undersigned recognizes that all physicians, medical associates and allied health professionals furnishing services to the patient, including but not limited to, emergency department physicians, dentists, radiologists, pathologists, radiation oncologists, anesthesiologists, psychologists, podiatrists, optometrists, certified registered nurse anesthesists and the like (except Daniel McGraw, MD; Shane Parmer, MD; David Farris, DO; Lisa Casalenuovo, DO; Joseph Boggs, MD; Gabor Altdorfer, MD; and Joseph Darrow, MD) are licensed independent practitioners and are not employees or agents of Camden-Clark Memorial Hospital. *INITIALS* RM

****

IF PATIENT IS INCOMPETENT TO GIVE CONSENT BECAUSE OF PHYSICAL CONDITION, AGE OR INCAPACITY COMPLETE THE FOLLOWING

1. Patient is unable to give consent because _____

Minor _____ year of age was _____ was not _____ accompanied by parent or guardian.

IF TELEPHONE CONSENT IS REQUIRED COMPLETE SECTION 2 IN ADDITION TO SECTION 1

2. (Name) _____ (Relationship to the minor) _____ was contacted by telephone on (Date and Time) _____ and the consent to Diagnosis and/or Treatment statement was fully explained. She/He stated understanding and gave verbal consent to provide necessary care.

****

This form has been fully explained to me and I acknowledge that I understand its contents.

Deniesa Robert E Marshall — daughter
Signature of Patient or Legally Authorized Representative — Relationship

Catherine Mitchell — 6-23-8 — 1148
Signature of Witness or Witnesses — Date — Time

Camden-Clark Memorial Hospital

For Your Lifetime

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

MARSHALL,ROBERT E
A: 34359224 U:00099473

I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling the Health Information Management Office at 304-424-2214, on this Organization's website at www.ccmh.org or by requesting one at this Organization's offices.

2-23-05
(Date)

Robert Marshall
(Signature*)

Robert Marshall
(Print or Type Name)

* As the representative of the above individual, I acknowledge receipt of the Notice on his or her behalf.

(Signature)

(Relationship)

(Date)

Camden-Clark Memorial Hospital
Physician Emergency Department Report

Name: MARSHALL,ROBERT E | **Account Number: 34359224**
E.D. Clinician: BAKER,DONALD J,MD | **Date: 02/23/09**
Family Doctor: BRAHAM,JEFFREY, DO. | **Age: 79**
Unit Number: 00099473 | **DOB: 05/08/29**
Location: ER

HPI:
02/23 This 79 years old White Male presents to ER via EMS-Ground with complaints of Fall Injury. db
12:48
12:48 The patient fell from an upright position. The symptoms began just prior to arrival. The patient sustained injury to the head, laceration, 2.5 cm(s), of the left eye. The patient has no apparent associated signs or symptoms, The patient experienced no loss of consciousness. patient also abraded and contused his left hand; patient is not on anticoagulants. db

Historical:
- Allergies: No known drug Allergies; Denies latex allergy;
- Home Meds:
1. Glucerna Oral;
2. Glyburide Oral;
3. Glucophage Oral;
4. Actos Oral;
- PMHx: Diabetes - IDDM; CAD; CHF;
- Family history:: Not pertinent.
- Social history:: The patient lives with family The patient denies using tobacco, alcohol, street drugs, IV drugs, over the counter diet medications, No barriers to communication noted. The patient speaks fluent English. Speaks appropriately for age.
- Code Status:: Full code.
- Immunization history:: Last tetanus immunization: unknown Pneumococcal vaccine is up to date. Flu vaccine is up to date.

ROS:
12:49 Skin: Positive for hematoma, laceration(s). db
All other systems are negative.

Exam:
12:49 Constitutional: This is a well developed, well nourished patient who is awake, alert, and in no acute distress. db
Neck: Trachea midline, no thyromegaly or masses palpated, and no cervical lymphadenopathy. Supple, full range of motion without nuchal rigidity, or vertebral point tenderness. No Meningismus.
Respiratory: Lungs have equal breath sounds bilaterally, clear to auscultation and percussion. No rales, rhonchi or wheezes noted. No increased work of breathing, no retractions or nasal flaring.
Cardiovascular: Regular rate and rhythm with a normal S1 and S2. No gallops, murmurs, or rubs. Normal PMI, no JVD. No pulse deficits.
Abdomen/GI: Soft, non-tender, with normal bowel sounds. No distension or tympany. No guarding or rebound. No evidence of tenderness throughout.
Back: No spinal tenderness. No costovertebral tenderness. Full range of motion.
12:49 Neuro: Awake and alert, GCS 15, oriented to person, place, time, and situation. Cranial nerves II-XII grossly intact. Motor strength 5/5 in all extremities. Sensory grossly intact. Cerebellar exam normal. Normal gait. db
Head/face: Noted is a laceration(s), 2.5cm(s), of the middle aspect of left

Camden-Clark Memorial Hospital
Physician Emergency Department Report

Name: MARSHALL,ROBERT E **Account Number: 34359224**
E.D. Clinician: BAKER,DONALD J,MD **Date: 02/23/09**
Family Doctor: BRAHAM,JEFFREY, DO. **Age: 79**
Unit Number: 00099473 **DOB: 05/08/29**
Location: ER

eyebrow and outer aspect of left eyebrow.

Vital Signs:
11:30 BP 144 / 65 RA Sitting (auto/reg); Pulse 66 MON; Resp 18; Temp 98.1; Pulse Ox 99% on R/A; Weight 95.24Kg / 210.00Lbs(R); Height 5 ft. 9 in. (175.26 cm) (R); Pain 5/10; pst
13:01 BP 140 / 66; Pulse 72; Resp 18; Pulse Ox 99% on R/A; Pain 0/10; ab

Laceration:
12:50 Wound Repair of 2.5cm (1.0in) full thickness laceration to middle aspect of left eyebrow and outer aspect of left eyebrow. Distal neuro/vascular/tendon intact. Anesthesia: Wound infiltrated with 1% lidocaine w/ Epi. Wound prep: Simple cleansing with betadine. Skin closed with 6-0 Nylon using Running sutures. db

MDM:
12:21 Patient medically screened. db
12:51 The history from nurses notes was reviewed and I agree with what is documented. Data reviewed: vital signs, nurses notes. Counseling: I had a discussion with the patient regarding: the historical points, exam findings, and any diagnostic results supporting the discharge/admit diagnosis. db

Signatures:

TORNES, PAM, RN	RN	pst
BAKER, DONALD, MD	MD	db

****

BAKER,DONALD J,MD

Disclaimer: This report has been electronically signed in the Medhost EDMS application.

cc:

Camden-Clark Memorial Hospital
Nurse Emergency Department Report

Name: MARSHALL,ROBERT E | **Account Number: 34359224**
E.D. Clinician: BAKER,DONALD J,MD | **Date: 02/23/09**
Family Doctor: BRAHAM,JEFFREY, DO. | **Age: 79**
Unit Number: 00099473 | **DOB: 05/08/29**
Location: ER

Presentation:
02/23 EMS-Ground pst
11:21
11:21 Less-Urgent pst
11:21 Presenting complaint: Patient states: fall-tripped over loose display in Circuit City and face planted. Acuity: Less-Urgent. Method of arrival: Ambulance. Care prior to arrival: None. See EMS report. Bleeding of injury controlled. Injury dressed. Activity prior to arrival: None. Mechanism of Injury: Fall from standing position. pst

Triage Assessment:
11:30 General: Patient is, in no apparent distress, Behavior is appropriate for age, cooperative. Pain: patient complains of generalized pain, Complains of pain in left eye. pst

Historical:
- Allergies: No known drug Allergies; Denies latex allergy;
- Home Meds:
1. Glucerna Oral;
2. Glyburide Oral;
3. Glucophage Oral;
4. Actos Oral;
- PMHx: Diabetes - IDDM; CAD; CHF;
- Family history:: Not pertinent.
- Social history:: The patient lives with family The patient denies using tobacco, alcohol, street drugs, IV drugs, over the counter diet medications, No barriers to communication noted. The patient speaks fluent English. Speaks appropriately for age.
- Code Status:: Full code.
- Immunization history:: Last tetanus immunization: unknown Pneumococcal vaccine is up to date. Flu vaccine is up to date.

Screening:
11:32 Abuse screen: Do you feel safe where you live? Yes. Are you afraid of anyone you love? No. Has anyone hit, kicked, shoved or bit you in the last year? No Has anyone made you do anything sexual you did not want to do? No. Nutritional screening: No deficits noted. Fall risk None identified. Tuberculosis screening: No symptoms or risk factors identified. Never had TB. Exposure risk/Travel Screening: None identified. pst

Assessment:
11:31 Neuro: Level of Consciousness is awake, alert, obeys commands, Oriented to person, place, time, Grips are equal bilaterally Moves all extremities. Reports headache. Derm: Reports pain. pst

Vital Signs:
11:30 BP 144 / 65 RA Sitting (auto/reg); Pulse 66 MON; Resp 18; Temp 98.1; Pulse Ox 99% on R/A; Weight 95.24Kg / 210.00Lbs(R); Height 5 ft. 9 in. (175.26 cm) (R); Pain 5/10; pst

PATIENT CARE INQUIRY (PCI: OE Database CAC)

Camden-Clark Memorial Hospital
Nurse Emergency Department Report

Name: MARSHALL,ROBERT E **Account Number: 34359224**
E.D. Clinician: BAKER,DONALD J,MD **Date: 02/23/09**
Family Doctor: BRAHAM,JEFFREY, DO. **Age: 79**
Unit Number: 00099473 **DOB: 05/08/29**
Location: ER

13:01 BP 140 / 66; Pulse 72; Resp 18; Pulse Ox 99% on R/A; Pain 0/10; ab

ED Course:
11:21 Patient moved to 11 pst
11:31 Arm band placed on right wrist. Patient placed in exam room Patient notified of wait time. Family accompanied patient. pst
11:33 Patient has correct armband on for positive identification. Placed in gown. Bed in low position. Call light in reach. Side rails up X2. pst

Outcome:
12:52 Discharge ordered by MD. db
13:01 Discharged to home ambulatory, with family, discharge instructions provided. Condition: good. Discharge instructions given to patient, family, Instructed on discharge instructions, follow up and referral plans. wound care, The patient verbalizes understnding of discharge instructions, wound care, Demonstrated understanding of instructions, their wound care. Additional hours of infusion: Not applicable. ab
13:01 Patient left the ED. ab

Signatures:

TORNES, PAM, RN	RN	pst
BAKER, DONALD, MD	MD	db
Barry, Angie, RN	RN	ab

****

Disclaimer: This report has been electronically signed in the Medhost EDMS application.

Camden-Clark Memorial Hospital

Department of Emergency Services
800 Garfield Avenue
Parkersburg, WV 26101
(304) 424-2355

DISCHARGE INSTRUCTIONS FOR: **Robert Marshall**
FOR TODAY'S VISIT ON: **Monday 2/23/2009**

Thank you for using Camden-Clark Memorial Hospital for your care today. It is important for you to know that the examination, treatment and x-ray reading you have received in the Emergency Care Center today have been rendered on an emergency basis only and are not intended to be a substitute for an effort to provide complete medical care. You should contact your follow-up physician as it is important that you let him or her check you and report any new or remaining problems since it is impossible to recognize and treat all elements of an injury or illness in a single emergency care center visit.

X-RAYS and LAB TESTS:
If you had x-rays today they were read by the emergency physician. Your x-rays will also be read by a radiologist within 24 hours. If there is any discrepancy, you will be contacted for appropriate follow-up. If your x-rays were negative, follow up x-rays or more sophisticated tests like CT or MRI may show a fracture or other abnormality. If you had a culture done it will take 24 to 72 hours to get results. If there is a change in the x-ray diagnosis or a positive culture we will contact you. **(Make sure we have your local phone number.)**

MEDICATIONS:
If you received a prescription for medication(s) today it is important that when you fill this you let the pharmacists know all the other medications that you are on and any allergies you might have. It is also important that you notify your follow-up physician of all your medications including the prescriptions you may receive today.

Care provided by BAKER, DONALD, MD with the diagnosis of Facial Laceration.

Thanks again for using Camden-Clark Memorial Hospital for your treatment today. The discharge instructions for today's visit are outlined below.

- Head Injury
- Laceration Care

1. YOUR PHYSICIAN (GENERAL MD STAFF)
- Suture Removal 5-6 days

Special Notes:

I hereby acknowledge that I have received and understand the above instructions and prescriptions (if any). I acknowledge that failure to follow-up with the above doctors as directed will release the emergency department physicians of any responsibility for any adverse outcome or worsening of any condition. I also understand that my signature authorizes Camden-Clark Memorial Hospital to release all or any part of my medical record (including, if applicable, information pertaining to AIDS/HIV testing, mental health records, and drug/alcohol treatment) to the referred physician(s) listed above.

X Robert Marshall
Robert Marshall
MRN # 00099473

ED Physician or Nurse

Discharge Instruc[redacted]for: Robert Marshall [redacted]

Date 2-23-09

Chart Copy

WV OEMS PATIENT CARE RECORD

U 324497

1ST RESPONDER

SQUAD NAME: [illegible] Amb. Service

MONTH / DAY / YEAR: 02 23 09

Squad # / STATION # / TRIP # / INCIDENT #

Patient Name: Marshall, Robert

Birthdate: 05 08 29

Patient Soc. Sec. #: 233-44-6847

Auto License # / State

Patient's Mailing Address: [illegible]

Race

City: [illegible] State: WV Zip: 2[illegible]

Phone #

Next of Kin (Parent or Guardian): [illegible]

Relationship (Circle One): Spouse / Other / Child

Insurance #1 / Subscriber Name / Policy/Group #

Insurance #2 / Subscriber Name / Policy/Group #

Auto Ins. / Agent / Policy #

Medicare Service Code: / Medicare Condition Codes:

Medicare # / Medicaid #

AMT / BLS / ALS Assessment / ALS / ALS 2 / Specialty Care Transport

USE 2400 HR.	HR	MIN
CALL RECEIVED	10	10
CALL DISPATCHED	10	49
ENROUTE	10	49
ARRIVAL SCENE	[illegible]	[illegible]
ARRIVAL PATIENT	[illegible]	[illegible]
LEFT SCENE	11	00
ARRIVAL DEST.	11	1[illegible]
BACK IN SERVICE	11	15
WAITING TIME		

MILEAGE	
AT ONSET	2[illegible]171
AT SCENE	2[illegible]1172
AT DESTINATION	2[illegible]1175
AT RETURN	2[illegible]1175
TOTAL MILEAGE	[illegible]
TOTAL BILLING	3

INCIDENT CAUSE

NATURE OF CALL: C1

MEDICAL / TRAUMA / MOI

TO: RCMH

TIME	RESP	PULSE	BP	EYE	VERBAL	MOTOR	GCS	TRAUMA SCORE		PUPILS	CARDIAC RHYTHM	SaO2	GLUCOSE	CO	TEMP.
1110	18	72	1[illegible]/90	4	5	6	2[illegible]	[illegible]	[illegible]	[illegible]	—	97	—	—	—

TIME	GA#	IV SITE	SOLUTION	CODE #
1.				

MARSHALL, ROBERT E
U00099473 ER DOS 02/23/09
05/08/1929 79 M
A34359224
BRAHAM, JEFFREY, DO.

TIME	MEDICATION	DOSE	RT	CODE #
1				
2				
3				
5				
6				

PREHOSPITAL CARE CHECK
- ☐ AED
- ☐ BLS ASSISTED MEDS.
- ☒ BLEEDING CONTROL
- ☐ CPR
- ☐ COLD/HOTPACKS
- ☐ DRESSING/WOUND CARE
- ☐ EXTRICATION ____ MINUTES
- ☐ OB DELIVERY
- ☐ ORAL/NASAL AIRWAY
- ☐ O_2 ____ lpm ☐ NRB ☐ CANNULA ☐ OTHER
- ☐ PASG APPLIED ☐ INFLATED
- ☐ VENTILATION ☐ BAG VALVE MASK ☐ MOUTH TO MASK ☐ DEMAND VALVE ☐ AUTO VENT
- ☐ SPLINT EXTREMITY
- ☐ SPINAL IMMOBILIZATION
- ☐ SUCTION
- ☐ GLUCOMETER
- ☐ PULSE OXIMETER
- ☐ CARDIAC MONITOR ☐ 3 LEAD ☐ 4 LEAD ☐ 12 LEAD
- ☐ CARDIOVERSION
- ☐ DEFIBRILLATION
- ☐ TC PACING
- ☐ CPAP
- ☐ CHEST DECOMPRESSION
- ☐ DC RESUSCITATION
- ☐ END TIDAL CO_2
- ☐ FLUID BOLUS ____ ml
- ☐ BLOOD DRAWN
- ☐ NG/OG TUBE

AGE 79 SEX M CHIEF COMPLAINT: 911 Call / Immediate Response 79M [illegible] fall (H) upon arrival, pt found lying on floor. Pt apparently got his [illegible] [illegible] [illegible] fell. Contusion on [illegible] hand. Pt A&O x3. Vitals stable. [illegible] 2cm lac to [illegible] hand (T) bleeding control (E). Pt [illegible] [illegible] (D) Pt [illegible] to RCMH [illegible] staff [illegible] care.

[illegible] Buck

#ATT.	✓SUCC.	CREW #
☐ CRICOTHYROTOMY		
☐ COMBITUBE		
☐ E T TUBE		
☐ INTRAOSSESOUS		
☐ IV START		

PROTOCOL #

HOSPITAL

Patient Condition on Arrival @ ED: ☒ Improved ☐ Unchanged ☐ Worse

Patient's Physician: Braham

Past Hx: Seizures, Diabetes, Heart Disease, Hypertension, Stroke, COPD, Other:

Pt. Meds: [illegible]

Allergies: ☒ NKA

	NAME	CERTIFICATE	SIGNATURE	DATE
1.	Buck	E 028191	[illegible] Buck	2/23/09
2.	[illegible]	P 028966		
3.				
4.				

SCENE GPS COORDS. N ☐☐ ☐☐ . ☐☐ W ☐☐ ☐☐ . ☐☐

RECEIPT OF PATIENT

_____ was received at _____ on _____ at _____
Patient's Name — Facility Name — Date — Time

List of patient belongings and valuables: _____

_____

Signed _____
Receiving Facility Representative

RELEASE FROM RESPONSIBILITY WHEN PATIENT REFUSES TREATMENT AND/OR SERVICES

THIS IS TO CERTIFY THAT I, _____ AM REFUSING RECOMMENDED TREATMENT, AND/OR SERVICES OFFERED BY THE EMS PERSONNEL, THE PHYSICIAN CONSULTANT, AND THE CONSULTING HOSPITAL. I ACKNOWLEDGE THAT I HAVE BEEN INFORMED OF THE RISK INVOLVED, AND HEREBY RELEASE THE ABOVE FROM ALL RESPONSIBILITY FOR ANY ILL EFFECTS WHICH MAY RESULT FROM THIS ACTION.

WITNESS _____ SIGNED _____
PATIENT'S NAME OR NEAREST RELATIVE

WITNESS _____ _____
RELATIONSHIP

RELEASE OF LIABILITY FOR ALTERNATE DESTINATION

This is to certify that the patient, legal guardian, parent, or Attorney-In-Fact, pursuant to the provisions of Section 22, Article 4C, Chapter 16 of the Code of West Virginia, has directed the emergency medical service personnel to transport this patient to a facility other than that directed by medical command and emergency medical service personnel and medical command shall be released from all liability from occurrences arising as a result of such directive.

_____
Patient, Parent, Guardian or Attorney-In-Fact

BILLING AUTHORIZATION, RESPONSIBILITY FOR PAYMENT AND RECEIPT OF NOTICE OF PRIVACY RIGHTS

I understand that I am financially responsible for the services provided to me by: _____ (EMS Provider) *regardless of insurance coverage. I request that payment of authorized Medicare or other insurance benefits be made on my behalf to* the EMS Provider for any service rendered to me by the EMS Provider. I authorize and direct any holder of medical information or documentation about me to release to the Centers for Medicare and Medicaid Services (CMS) and its carriers and agents, as well as to the EMS Provider and its billing agents and any other payers or insurers, any information or documentation needed to determine these benefits or benefits payable for any services rendered to me by the EMS Provider now, or in the future. I agree to immediately remit to the EMS Provider any payments that I receive directly from any source for the services rendered to me and I assign all rights to such payments to the EMS Provider. CMS carriers and agents only authorize payment for services determined as reasonable and medically necessary. CMS carriers & agents will deny payment for non-emergency and/or elective ambulance services. I agree to pay for any such services rendered to me if payment is denied.

I also acknowledge that I have received a copy of the EMS Provider's Notice of Privacy Practices.
A copy of this form is as valid as the original.

_____ _____, or
Patient's Signature — Date

_____ _____ _____
Patient Representative's Signature — Relationship to Patient — Date

Patient unable to sign because: _____

CAMDEN-CLARK MEMORIAL HOSPITAL
Parkersburg, WV 26102

REGISTRATION FORM

PATIENT NAME/ADDRESS	ACCOUNT NO.	ROOM/BED	TYPE	LOCATION/SERVICE	UNIT NO./MR#
MARSHALL,ROBERT E 77 LITTLE ADDITION RD DAVISVILLE,WV 26142 PHONE: 304-422-2891 SOCIAL SECURITY NO.: 233-44-6849 EMPLOYER: RETIRED	34359950		CLI	CCMHAMB	00099473

DATE OF BIRTH	AGE	SEX	MAR. STAT.	RELIGION	RACE
05/08/29	79	M	D	PRO	

GUARANTOR/ADDRESS	PERSON TO NOTIFY/ADDRESS	RELATIONSHIP: DAU
MARSHALL,ROBERT E 77 LITTLE ADDITION RD DAVISVILLE,WV 26142 PHONE: 304-422-2891 RELATIONSHIP: SAME AS PATIENT (SELF) GUAR. EMPLOYER: RETIRED	MARSHALL,BRENDA 1308 W VIRGINIA AVE PARKERSBURG,WV 26104 HOME PHONE: 304-428-4753 WORK PHONE:	

FINANCIAL CLASS: MC	NEXT OF KIN/ADDRESS	RELATIONSHIP: DAU
	GARD,TERRI 624 HOMEWOOD RD PARKERSBURG,WV 26101 HOME PHONE: 304-488-8993 WORK PHONE:	

INSURANCE NAME	POLICY NUMBER	GROUP NUMBER	SUBSCRIBER/INSURED NAME
ADVANTRA FREEDOM - MEDICARE	80127599301	7604300440	MARSHALL,ROBERT E

ACCIDENT INFORMATION	REASON FOR VISIT
-OTHER ACCIDENT-	FALL INJURY

ACCIDENT DATE/TIME	COMMENTS	HEIGHT/WEIGHT	ARRIVAL MODE	USER
02/23/09 /	TRANSPORTED TO CCMH	U U	CCMH AMB	CR-WLN

ADMIT DATE/TIME	ADMITTING PHYSICIAN	ATTENDING PHYSICIAN	OTHER PHYSICIAN	PRIMARY CARE PHYSICIAN
02/23/09 1049		BRAHAM,JEFFREY, DO.		

HOSP.DAYS	H OMI SNF ICF HH DIED AUT	SURGEON:	CONSULT:	DISCH DATE/TIME
		ANESTHESIOLOGIST:	CONSULT:	

ADMITTING DIAGNOSIS

PRINCIPAL DIAGNOSIS

SECONDARY DIAGNOSIS

PROCEDURES

DIAGNOSIS AND PROCEDURE CODE

I certify that the narrative descriptions of the principal and secondary diagnoses and the major procedures performed are accurate and complete to the best of my knowledge.

Attending Physician DATE

MEDICAL RECORD SUMMARY SHEET

CAMDEN-CLARK MEMORIAL HOSPITAL
PARKERSBURG, WEST VIRGINIA 26101

[redacted]

CONSENT TO DIAGNOSIS AND/OR TREATMENT

I, MARSHALL,ROBERT E:34359950 hereby authorize the staff of CAMDEN-CLARK MEMORIAL [redacted] to perform any and/or all procedures and treatments ordered in the diagnosis and treatment of my disorder. [redacted] any of my physicians deem it necessary that I be administered an anesthetic, other than a local anesthe[redacted] undergo a surgical or other hazardous diagnostic or therapeutic procedure, a separate consent will be req[redacted]ware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantee [redacted]de to me as to the results of the examination, diagnostic procedure or treatment. In accordance with th[redacted]e Hospital, CAMDEN-CLARK MEMORIAL HOSPTIAL, is hereby authorized to furnish such professional information fr[redacted] record to any physician and/or health care facility engaged in my subsequent medical care. *INITIALS*_____

STUDENT EDUCATION

Camden-Clark Memorial Hospital maintains educational affiliations with area and regional schools [redacted] purpose of providing clinical experiences to their students. I understand and agree that students may par[redacted] be present at various times during my care at Camden-Clark Memorial Hospital. *INITIALS*_____

PAYMENT GUARANTEE/ASSIGNMENT OF INSURANCE BENEFITS/AUTHORIZATION TO BILL THIRD [redacted]

I, hereby authorize direct payment to Camden-Clark Memorial Hospital the benefits herein specif[redacted]wise payable to me. I also authorize direct payment to the physicians responsible for my care for charges for th[redacted] I understand I am financially responsible to the Hospital and physicians for all charges.
I further authorize the release of medical information to any third party payor or agent thereo[redacted]
Where applicable, I authorize the Hospital to apply for payment under Title XVIII of the Social [redacted] I authorize release of any information given by me in applying for such payment and certify that such inform[redacted]e and correct. I request that payment of authorized benefits be made in my behalf. I understand I am responsib[redacted]pplicable health insurance deductibles and coinsurance. *INITIALS*_____

RELEASE OF LIABILITY FOR PERSONAL PROPERTY

I have been told that I should send all valuables and money home. If I do not, I hereby agree a[redacted]ge that I alone will be solely responsible for the safekeeping of personal property including, but not limited to [redacted]dal aids, hearing aids, dentures and jewelry which I have by choice retained in my possession while I am [redacted] Camden-Clark Memorial Hospital. I do hereby release Camden-Clark Memorial Hospital, its agents and employee[redacted] all liability for loss, theft or damage to such property. *INITIALS*_____

PHYSICIAN AND ALLIED HEALTH SERVICES

The undersigned recognizes that all physicians, medical associates and allied health profession[redacted] services to the patient, including but not limited to, emergency department physicians, dentists, radiologis[redacted]ists, radiation oncologists, anesthesiologists, psychologists, podiatrists, optometrists, certified registered n[redacted]sists and the like (except Daniel McGraw, MD; Shane Parmer, MD; David Farris, DO; Lisa Casalenuovo, DO; Joseph [redacted] Gabor Altdorfer, MD; and Joseph Darrow, MD) are licensed independent practitioners and are not employees or agents o[redacted] Memorial Hospital. *INITIALS*_____

****

IF PATIENT IS INCOMPETENT TO GIVE CONSENT BECAUSE OF PHYSICAL CONDITION, AGE OR INCAPACITY COMPL[redacted]OWING

1. Patient is unable to give consent because _____

Minor _____ year of age was _____ was not _____ accompanied by parent or guard[redacted]

IF TELEPHONE CONSENT IS REQUIRED COMPLETE SECTION 2 IN ADDITION TO SECTI[redacted]

2. (Name) _____ (Relationship to the minor) _____ wa[redacted] by telephone on (Date and Time) _____ and the consent to Diagnosis and/or Treatment statement [redacted] explained. She/He stated understanding and gave verbal consent to provide necessary care.

****

This form has been fully explained to me and I acknowledge that I understand its contents.

_____ _____
Signature of Patient or Legally Authorized Representative Relationship

_____ _____
Signature of Witness or Witnesses Date [redacted]me

343599950 010099473

WV OEMS PATIENT CARE RECORD U 324497

Squad Name: CCMH Amb Service
Month/Day/Year: 02 23 09 — Vehicle #: C1132 — Unit #: 1914

Squad #: 43HB — Station #: 3 — Trip #: CC457 — Incident #: 00891

Name: Marshall, Robert
Birthdate (Mo/Day/Yr): 05 08 29 — Patient Soc. Sec. #: 233446849 — Auto License # — State — 1ST RESPONDER

Patient's Mailing Address: 1 Little Addition Rd — Race: 01
City: Daireville — State: WV — 26142 — Phone #: 304-422-2891
Zip: 26105 — Circuit City — 67
Next of Kin (Parent or Guardian): Terri Gard — Relationship (Circle One): Spouse / Other / (Child)
Insurance #1: PEIA — Subscriber Name — Policy/Group #
Insurance #2 — Subscriber Name — Policy/Group #
Auto Ins. — Agent — Policy #
Medicare: ADVANTRA — Medicare Condition Codes:
Medicaid #: 7080127599301 — Medicaid #

☐ AMT ☐ BLS ☒ ALS Assessment ☐ ALS ☐ ALS 2 ☐ Specialty Care Transport

USE 2400 HR.	HR	MIN
CALL RECEIVED	10	46
CALL DISPATCHED	10	49
ENROUTE	10	49
ARRIVAL SCENE	10	53
ARRIVAL PATIENT	10	53
LEFT SCENE	11	08
ARRIVAL DEST.	11	15
BACK IN SERVICE	11	15
WAITING TIME		

MILEAGE	
AT ONSET	24171
AT SCENE	24172
AT DESTINATION	24175
AT RETURN	24175
TOTAL MILEAGE	4
TOTAL BILLING	3

02 / 02 / 02 / 01

INCIDENT CAUSE — NATURE OF CALL: 01 — 1040 — 401
MEDICAL — TRAUMA: 30, 41 — MOI: 10 — K07, 082
TO: CCMH

TIME			BP								CARDIAC RHYTHM	SaO2	GLUCOSE		TEMP.
1110	18	72	140/90	4	5	6	2	1	116	upd	PERL	—	99	—	—

TIME	GA#	IV SITE	SOLUTION	CODE #	TIME	GA#	IV SITE 2	SOLUTION	CODE #
1.					2.				

	TIME	MEDICATION	DOSE - RT	CODE #	TIME	MEDICATION	DOSE - RT	CODE #
1					4			
2					5			
3					6			

☐ AED
☐ BLS ASSISTED MEDS.
☒ BLEEDING CONTROL
☐ CPR
☐ COLD/HOTPACKS
☐ DRESSING/WOUND CARE
☐ EXTRICATION ______ MINUTES
☐ OB DELIVERY
☐ ORAL/NASAL AIRWAY
☐ O_2 ______ lpm
☐ NRB ☐ CANNULA ☐ OTHER
☐ PASG APPLIED ☐ INFLATED
☐ VENTILATION
☐ BAG VALVE MASK ☐ MOUTH TO MASK
☐ DEMAND VALVE ☐ AUTO VENT
☐ SPLINT EXTREMITY
☐ SPINAL IMMOBILIZATION
☐ SUCTION
☐ GLUCOMETER
☒ PULSE OXIMETER
☐ CARDIAC MONITOR
☐ 3 LEAD ☐ 4 LEAD ☐ 12 LEAD
☐ CARDIOVERSION
☐ DEFIBRILLATION
☐ TC PACING
☐ CPAP
☐ CHEST DECOMPRESSION
☐ DC RESUSCITATION
☐ END TIDAL CO_2
☐ FLUID BOLUS ______ ml
☐ BLOOD DRAWN
☐ NG/OG TUBE

#ATT. ✓ SUCC. CREW #
☐ CRICOTHYROTOMY
☐ COMBITUBE
☐ E T TUBE
☐ INTRAOSSESOUS
☐ IV START
PROTOCOL #

SQUAD

AGE 79 SEX M CHIEF COMPLAINT: 911 Call / Immediate Response 79M c/o fall. (H) Upon arrival, pt found lying on floor. Pt apparently got his foot caught on a shelf & fell, landing on his face & hand. Pt hx: DM (E/A) Pt A+O x3. Vitals stable. 1-7cm lac above L eye. 1-2cm lac to L hand (T) Bleeding control (E) Pt rested en route (D) Pt transported to CCMH. Staff assumed care.

Angela Buck

Patient Condition on Arrival @ ED: ☒ Improved ☐ Unchanged ☐ Worse — Patient's Physician: Braham

Past Hx: Seizures, (Diabetes), Heart Disease, Hypertension, Stroke, COPD, Other:

Pt. Meds: list w/ pt & staff — Allergies: ☒ NKA

	NAME	CERTIFICATE	SIGNATURE	DATE
1.	Buck	E058491	Angela Buck	2/23/09
2.	Keller	P028966		
3.				
4.				

SCENE GPS COORDS. N ☐☐ ☐☐ . ☐☐ W ☐☐ ☐☐ . ☐☐

RECEIPT OF PATIENT

_____ was received at _____ on _____ at _____
Patient's Name — Facility Name — Date — Time

List of patient belongings and valuables: _____

_____

Signed _____
Receiving Facility Representative

RELEASE FROM RESPONSIBILITY WHEN PATIENT REFUSES TREATMENT AND/OR SERVICES

THIS IS TO CERTIFY THAT I, _____ AM REFUSING RECOMMENDED TREATMENT, AND/OR SERVICES OFFERED BY THE EMS PERSONNEL, THE PHYSICIAN CONSULTANT, AND THE CONSULTING HOSPITAL. I ACKNOWLEDGE THAT I HAVE BEEN INFORMED OF THE RISK INVOLVED, AND HEREBY RELEASE THE ABOVE FROM ALL RESPONSIBILITY FOR ANY ILL EFFECTS WHICH MAY RESULT FROM THIS ACTION.

WITNESS _____ SIGNED _____
PATIENT'S NAME OR NEAREST RELATIVE

WITNESS _____
RELATIONSHIP

RELEASE OF LIABILITY FOR ALTERNATE DESTINATION

This is to certify that the patient, legal guardian, parent, or Attorney-In-Fact, pursuant to the provisions of Section 22, Article 4C, Chapter 16 of the Code of West Virginia, has directed the emergency medical service personnel to transport this patient to a facility other than that directed by medical command and emergency medical service personnel and medical command shall be released from all liability from occurrences arising as a result of such directive.

_____
Patient, Parent, Guardian or Attorney-In-Fact

BILLING AUTHORIZATION, RESPONSIBILITY FOR PAYMENT AND RECEIPT OF NOTICE OF PRIVACY RIGHTS

I understand that I am financially responsible for the services provided to me by: _____ (EMS Provider) regardless of insurance coverage. I request that payment of authorized Medicare or other insurance benefits be made on my behalf to the EMS Provider for any service rendered to me by the EMS Provider. I authorize and direct any holder of medical information or documentation about me to release to the Centers for Medicare and Medicaid Services (CMS) and its carriers and agents, as well as to the EMS Provider and its billing agents and any other payers or insurers, any information or documentation needed to determine these benefits or benefits payable for any services rendered to me by the EMS Provider now, or in the future. I agree to immediately remit to the EMS Provider any payments that I receive directly from any source for the services rendered to me and I assign all rights to such payments to the EMS Provider. CMS carriers and agents only authorize payment for services determined as reasonable and medically necessary. CMS carriers & agents will deny payment for non-emergency and/or elective ambulance services. I agree to pay for any such services rendered to me if payment is denied.

I also acknowledge that I have received a copy of the EMS Provider's Notice of Privacy Practices.
A copy of this form is as valid as the original.

X Robert E. Marshall — 2/23/09, or
Patient's Signature — Date

_____ _____ _____
Patient Representative's Signature — Relationship to Patient — Date

Patient unable to sign because: _____

✓ 34359950 00699473

AMBULANCE SERVICES REPORT Dr. D. Baker

IDENTIFICATION DATA
Patient's Name: Marshall, Robert
Medicare HIC#: 801275993D1
Name of Provider: CAMDEN CLARK MEMORIAL HOSP
Provider Number: 510058
Date of Service: 2/23/09

BILLING DATA.
Base Transport Charge: 463.00
Milage Rate: 12.00 x 3 Mile = 36.00
Other Charges: (Explain)
TOTAL: 499.00

TRANSPORTATION DATA.
Point of Pickup: Circuit City
405 Grand Central Ave
Vienna, WV 26105
Destination: []Home []SNF/ICF []Dr.Office
[X]Acute Care Hosp./ER []Other (Explain)
CCMH ER, 800 Garfield Ave Parkersburg, WV 26102
Was patient admitted to your facility?
[]YES [X]NO
Mode of Transport []Wheelchair [X]Stretcher
[]Other

CERTIFICATION DATA.
I certify that the patient's condition of ___ definitely contraindicated the use of other means transportation/ regardless of its availability.

Physician Signature Date

PURPOSE OF TRANSPORT
The patient was suffering from an illness or injury which contradicted transportation by other means. Specifically, the need(s) of the patient included the following:

[X] Was transported in an emergency situation. (Describe the emergency.) Fall + head injury
[ ] Needed to be restrained. (Describe the need.)
[ ] Required (ALS/BLS) emergency treatment on the way to his distination. (Describe the specific needs.)
[ ] Had to remain immobile, because of a fracture: (Describe immobilizing needs or situation)
[ ] Was bed confined before and after the ambulance trip. (Report the length of confinement, and record specifics of the patient's bedridden status.)
[ ] Patient/Family Request.
[ ] Patient's attending physician at another facility.
[X] Other: Pt fell, injuring his head + L hand. Bleeding Control Necessary

Angela Buck NREMTB 2/23/09
Signature & Title Date

GEORGE J. COSENZA, PLLC

Admitted In West Virginia and Ohio

ATTORNEY AT LAW

515 Market Street · Post Office Box 4
Parkersburg, West Virginia 26102
e-mail: cosenza@wvdsl.net

(304) 485-0990
Fax (304) 485-1090

July 17, 2009

Jeffrey T. Braham, D.O.
Mid-Ohio Valley Medical Group, Inc.
800 Grand Central Mall, Suite 4
Vienna, WV 26105

Re: Robert E. Marshall
DOB: 5/08/29
SSN: 273-44-6849

Dear Dr. Braham:

I represent the interests of Robert E. Marshall. Mr. Marshall has requested that I obtain copies of all of his medical records currently in your possession concerning your treatment of him for injuries suffered in a fall on February 23, 2009. I have enclosed the appropriate authorization forms for same. In addition, I would appreciate you providing me with **AN ITEMIZED STATEMENT INDICATING ALL CHARGES FOR SERVICES RENDERED**. Please provide this information to my office as soon as possible. If there are any costs for these documents, please contact me or include a statement for the amount due with the records, and I will reimburse you for same upon receipt of the package.

Thank you for your cooperation in this matter. If you have any questions, please do not hesitate to contact me.

Very truly yours,

George J. Cosenza

George J. Cosenza

GJC/tap
Enclosure

cc: Robert E. Marshall

MID OHIO VALLEY MEDICAL GROUP
800 GRAND CENTRAL MALL
VIENNA, WV 26105-4131
(304) 485-3300

Print Date: 07/24/2009 2:58 pm

Order Status: **All Results Signed**
05/19/2009 1:00 pm

MARSHALL, ROBERT E
77 LITTLE ADDITION RD
DAVISVILLE, WV 26142

Patient ID/# 80652 **DOB** 05/08/1929 **Age** 80 years **Gender** Male
SSN: 233-44-6849
Home Phone (304) 422-2891
Work Phone (555) 555-5555 **Fasting** No

Ordering LILIA A UNDERWOOD FNPBC

Referring JEFFERY T BRAHAM
BRAHAM
800 GRAND CENTRAL MALL
VIENNA, WV 26105

Copy To

Order # 217805 **Order Service Date** 05/12/2009 1:36 pm **LIS Order Accession #**
Specimen Collection Date 05/12/2009 10:41 am **Order Sent To LIS** 05/19/2009 10:41 am
Order Comments
Tests Ordered X-RAY FEMUR LEFT; X-RAY HIP LEFT

TEST DESCRIPTION	RESULTS	REFERENCE RANGE	UNITS

X-RAY FEMUR LEFT

Test Ordered Date: 05/12/2009 1:36 pm
Performing Lab: 3 Verified By:
OTHER XRAY
See attached image (#1) .

Test Status: Complete

Result Date/Status: 05/19/2009 10:42 am F

FINAL: Electronically signed by Lilia A. Underwood, FNP-BC on 05/19/2009 1:00 pm

X-RAY HIP LEFT

Test Ordered Date: 05/12/2009 1:36 pm
Performing Lab: 3 Verified By:
OTHER XRAY
See attached image (#1) .

Test Status: Complete

Result Date/Status: 05/19/2009 10:42 am F

FINAL: Electronically signed by Lilia A. Underwood, FNP-BC on 05/19/2009 1:00 pm

Tests Performed At 3 RADIOLOGICAL TESTS
800 GRAND CENTRAL MALL
VIENNA, WV 26105
Ph: (304) 485-3300 CLIA:

Result Status:
P = Preliminary F = Final CF = Corrected/Final
C = Corrected EIE = Entered In Error CP = Corrected/Preliminary

PatientID: 80652 Date of Birth: 05/08/1929
Patient Name: ROBERT E MARSHALL Date of Service: 05/12/2009
MRC Description: OTHER XRAY

P

~ PARKERSBURG RADIOLOGY SERVICES, INC.
~ 800 Grand Central Mall Suite 7
~ Vienna, WV 26105

W. Michael Hensley, MD Terry C. Shank, MD Kenneth T Miller, MD
Bernard O. Garrett, DO ~ Craig A. Chambers, DO

~ DATE 5/12/09

Jeffery T Braham DO
Mid-Ohio Valley Medical Group ~ Lilia Underwood FNPBC
800 Grand Central Ave
Vienna, WV 26105

NAME Marshall, Robert E ~ AGE 5/8/29

ADDRESS 77 Little Add Rd Davisville WV ~ X-RAY C2896

REASON FOR EXAM: Fell. Pain.

PELVIS AND LEFT HIP:
Examination of the pelvic structures fails to show a fracture or definite abnormality. No definite fractures are seen about the pubic ramii. Examination of the hip fails to show a fracture, dislocation or definite abnormality.

IMPRESSION:
1. Negative examination of the pelvis and left hip.

LEFT FEMUR - TWO VIEWS:
AP and lateral views were obtained and demonstrate no acute or healing fracture or other abnormality.

CONCLUSION:
1. No fracture identified.

Thank you for allowing us to examine your patient in our office.

W Michael Hensley M.D.

WMH/tw
dict/trans 05/13/09 ~ W. Michael Hensley, MD Radiologist

~ 1

5/13/09 Note

Final: Electronically signed by Lilia A. Underwood, FNP-BC on 05/19/2009 at 1:00:44 pm
Final: Electronically signed by Lilia A. Underwood, FNP-BC on 05/19/2009 at 1:00:44 pm

From: emrjr
To: emrjr
Action Date: 06/03/2009 Created Date: 06/03/2009
PT NOTIFIED. DECLINES DIABETIC ED AT PRESENT. STATES HE WILL THINK ABOUT IT AND GET BACK WITH US LATER. DR BRAHAM NOTIFIED. COMPLETE AND FINALIZED

From: emrjr
To: emrjr
Action Date: 06/03/2009 Created Date: 06/03/2009
Left message on answering machine for patient to call back.

From: emrjr
To: emrjr
Action Date: 06/03/2009 Created Date: 06/03/2009
ALSO HAS XRAY

From: emrjtb
To: emrjr
Action Date: 06/03/2009 Created Date: 06/03/2009
SUGARS TOO HIGH
D.E. WILL PROBABLY NEED INSULIN

MID OHIO VALLEY MEDICAL GROUP
610 WASHINGTON BLVD, STE 1
BELPRE, OH 45714
(304) 485-3300

Print Date: 07/24/2009 2:58 pm
Order Status: **All Results Signed 06/03/2009 8:12 am**

MARSHALL, ROBERT E
77 LITTLE ADDITION RD
DAVISVILLE, WV 26142

Patient ID/# 80652 **DOB** 05/08/1929 **Age** 80 years **Gender** Male
SSN: 233-44-6849
Home Phone (304) 422-2891
Work Phone (555) 555-5555 **Fasting** No

Ordering JEFFERY T BRAHAM DO
Referring JEFFERY T BRAHAM
BRAHAM
800 GRAND CENTRAL MALL
VIENNA, WV 26105
Copy To

Order # 221912 **Order Service Date** 05/27/2009 8:51 am **LIS Order Accession #** 09147200
Specimen Collection Date 05/27/2009 8:57 am **Order Sent To LIS** 05/27/2009 8:57 am
Order Comments
Tests Ordered COMPREHENSIVE METABOLIC PROF; HEMOGLOBIN A1C; LIPID PROFILE

COMPREHENSIVE METABOLIC PROF

Test Ordered Date: 05/27/2009 8:51 am
Performing Lab: 1 Verified By: 05/27/2009 3:46 pm
Test Status: Complete
Test Accession #: 09147200

TEST DESCRIPTION	RESULTS		REFERENCE RANGE	UNITS	
ALBUMIN	4.0		3.5 - 5.0	g/dL	F
			Result Date/Status: 05/27/2009 3:46 pm		
ALK. PHOS	92		38 - 126	U/L	F
			Result Date/Status: 05/27/2009 3:46 pm		
ALT (SGPT)	**16**	**L**	**21 - 72**	**U/L**	F
			Result Date/Status: 05/27/2009 3:46 pm		
AST (SGOT)	22		17 - 59	U/L	F
			Result Date/Status: 05/27/2009 3:46 pm		
BUN	**24**	**H**	**9 - 20**	**mg/dL**	F
			Result Date/Status: 05/27/2009 3:46 pm		
CALCIUM	9.3		8.4 - 10.2	mg/dL	F
			Result Date/Status: 05/27/2009 3:46 pm		
CHLORIDE	103		98 - 107	mmol/L	F
			Result Date/Status: 05/27/2009 3:46 pm		
CREATININE	1.19		0.66 - 1.25	mg/dL	F
			Result Date/Status: 05/27/2009 3:46 pm		
CARBON DIOXIDE	25		22 - 30	mmol/L	F
			Result Date/Status: 05/27/2009 3:46 pm		
GLUCOSE	**168**	**H**	**74 - 106**	**mg/dL**	F
			Result Date/Status: 05/27/2009 3:46 pm		

Result Status:
P = Preliminary F = Final CF = Corrected/Final
C = Corrected EIE = Entered In Error CP = Corrected/Preliminary

MID OHIO VALLEY MEDICAL GROUP
610 WASHINGTON BLVD, STE 1
BELPRE, OH 45714
(304) 485-3300

Print Date: 07/24/2009 2:58 pm

Order Status: **All Results Signed**
06/03/2009 8:12 am

MARSHALL, ROBERT E
77 LITTLE ADDITION RD
DAVISVILLE, WV 26142

Patient ID/# 80652 **DOB** 05/08/1929 **Age** 80 years **Gender** Male
SSN: 233-44-6849
Home Phone (304) 422-2891
Work Phone (555) 555-5555
Fasting No

Ordering JEFFERY T BRAHAM DO

Referring JEFFERY T BRAHAM
BRAHAM
800 GRAND CENTRAL MALL
VIENNA, WV 26105

Copy To

Order # 221912 **Order Service Date** 05/27/2009 8:51 am **LIS Order Accession #** 09147200
Specimen Collection Date 05/27/2009 8:57 am **Order Sent To LIS** 05/27/2009 8:57 am
Order Comments
Tests Ordered COMPREHENSIVE METABOLIC PROF; HEMOGLOBIN A1C; LIPID PROFILE

TEST DESCRIPTION	RESULTS		REFERENCE RANGE	UNITS

COMPREHENSIVE METABOLIC PROF

Test Ordered Date: 05/27/2009 8:51 am
Performing Lab: 1 Verified By: 05/27/2009 3:46 pm
Test Status: Complete
Test Accession #: 09147200

SODIUM	141		137 - 145	mmol/L
			Result Date/Status: 05/27/2009 3:46 pm	F
TOTAL BILIRUBIN	0.21		0.00 - 1.30	mg/dL
			Result Date/Status: 05/27/2009 3:46 pm	F
TOTAL PROTEIN	7.7		6.3 - 8.2	g/dL
			Result Date/Status: 05/27/2009 3:46 pm	F
POTASSIUM	**5.2**	**H**	**3.5 - 5.1**	**mmol/L**
			Result Date/Status: 05/27/2009 3:46 pm	F
GFR	**58.82**	**L**	**> 60.00**	**mL/min**
			Result Date/Status: 05/27/2009 3:46 pm	F

```
***NO HEMOLYSIS PRESENT***
*  If the patient is African American multiply the GFR
result by 1.21.
*  Results calculated greater than 60 should not be interpreted
as an exact number.
```

FINAL: Electronically signed by Jeffery Braham DO on 06/03/2009 8:12 am

HEMOGLOBIN A1C

Test Ordered Date: 05/27/2009 8:51 am
Performing Lab: 1 Verified By: 05/27/2009 4:10 pm
Test Status: Complete
Test Accession #: 09147200

HEMOGLOBIN A1C	**9.3**	**H**	**4.3 - 6.1**	**%**
			Result Date/Status: 05/27/2009 4:10 pm	F

FINAL: Electronically signed by Jeffery Braham DO on 06/03/2009 8:12 am

LIPID PROFILE

Test Ordered Date: 05/27/2009 8:51 am
Performing Lab: 1 Verified By: 05/27/2009 3:46 pm
Test Status: Complete
Test Accession #: 09147200

CHOLESTEROL	180		0 - 199	mg/dL
			Result Date/Status: 05/27/2009 3:46 pm	F
TRIGLYCERIDES	**336**	**H**	**0 - 149**	**mg/dL**
			Result Date/Status: 05/27/2009 3:46 pm	F
DHDL	**38**	**L**	**40 - 60**	**mg/dl**
			Result Date/Status: 05/27/2009 3:46 pm	F
LDL (CALCULATED)	76		0 - 130	CALC
			Result Date/Status: 05/27/2009 3:46 pm	F
VLDL (CALCULATED)	**67**	**H**	**0 - 39**	**mg/dl**
			Result Date/Status: 05/27/2009 3:46 pm	F

FINAL: Electronically signed by Jeffery Braham DO on 06/03/2009 8:12 am

Result Status:
P = Preliminary F = Final CF = Corrected/Final
C = Corrected EIE = Entered In Error CP = Corrected/Preliminary

MID OHIO VALLEY MEDICAL GROUP
610 WASHINGTON BLVD, STE 1
BELPRE, OH 45714
(304) 485-3300

Print Date: 07/24/2009 2:58 pm

Order Status: **All Results Signed**
06/03/2009 8:12 am

MARSHALL, ROBERT E
77 LITTLE ADDITION RD
DAVISVILLE, WV 26142

Patient ID/# 80652 **DOB** 05/08/1929 **Age** 80 years **Gender** Male
SSN: 233-44-6849
Home Phone (304) 422-2891
Work Phone (555) 555-5555
Fasting No

Ordering JEFFERY T BRAHAM DO

Referring JEFFERY T BRAHAM
BRAHAM
800 GRAND CENTRAL MALL
VIENNA, WV 26105

Copy To

Order # 221912 **Order Service Date** 05/27/2009 8:51 am **LIS Order Accession #** 09147200
Specimen Collection Date 05/27/2009 8:57 am **Order Sent To LIS** 05/27/2009 8:57 am

Order Comments

Tests Ordered COMPREHENSIVE METABOLIC PROF; HEMOGLOBIN A1C; LIPID PROFILE

TEST DESCRIPTION	RESULTS	REFERENCE RANGE	UNITS

Tests Performed At	1	MID OHIO VALLEY MEDICAL GROUP 800 GRAND CENTRAL MALL PARKERSBURG, WV 26105	Ph: (304) 485-3300 Lab Director	CLIA: 51D0236031

Result Status:
P = Preliminary F = Final CF = Corrected/Final
C = Corrected EIE = Entered In Error CP = Corrected/Preliminary

MID OHIO VALLEY MEDICAL GROUP
610 WASHINGTON BLVD, STE 1
BELPRE, OH 45714
(304) 485-3300

Print Date: 07/24/2009 2:58 pm

Order Status: **All Results Signed**
06/05/2009 2:57 pm

MARSHALL, ROBERT E
77 LITTLE ADDITION RD
DAVISVILLE, WV 26142

Patient ID/# 80652 **DOB** 05/08/1929 **Age** 80 years **Gender** Male
SSN: 233-44-6849
Home Phone (304) 422-2891
Work Phone (555) 555-5555 **Fasting** No

Ordering JEFFERY T BRAHAM DO

Referring JEFFERY T BRAHAM
BRAHAM
800 GRAND CENTRAL MALL
VIENNA, WV 26105

Copy To

Order # 221911 **Order Service Date** 05/27/2009 8:51 am **LIS Order Accession #**
Specimen Collection Date 05/28/2009 2:40 pm **Order Sent To LIS** 06/05/2009 2:40 pm
Order Comments
Test Ordered X-RAY LUMBAR SPINE

TEST DESCRIPTION	RESULTS	REFERENCE RANGE	UNITS

X-RAY LUMBAR SPINE

Test Ordered Date: 05/27/2009 8:51 am
Test Status: Complete
Performing Lab: 3 Verified By:
OTHER XRAY
See attached image (#1) .

Result Date/Status: 06/05/2009 2:40 pm F

FINAL: Electronically signed by Jeffery Braham DO on 06/05/2009 2:57 pm

Tests Performed At 3 RADIOLOGICAL TESTS Ph: (304) 485-3300 CLIA:
800 GRAND CENTRAL MALL
VIENNA, WV 26105

Result Status:
P = Preliminary F = Final CF = Corrected/Final
C = Corrected EIE = Entered In Error CP = Corrected/Preliminary

PatientID: 80652
Patient Name: ROBERT E MARSHALL
MRC Description: OTHER XRAY
Date of Birth: 05/08/1929
Date of Service: 05/28/2009

M

PARKERSBURG RADIOLOGY SERVICES, INC
800 Grand Central Mall Suite 7
Vienna, West Virginia 26105

W. Michael Hensley, MD Terry C. Shank, MD Kenneth T. Miller, MD
Bernard O. Garrett, DO Craig A. Chambers, DO

DATE: 5/28/09

Mid Ohio Valley Medical Group
800 Grand Central Mall
Vienna, WV 26105

Jeffery Braham DO

NAME: Marshall, Robert E 422 - 2891
ADDRESS: 77 Little Add Rd Davisville WV

AGE: 5/8/29
X-RAY: C-3279

REASON FOR EXAM: Pain left hip and down leg. Fell in February.

LUMBAR SPINE –THREE VIEWS:
AP, lateral and spot projection of the lumbosacral junction were obtained.

The lumbar vertebral body heights are well maintained.

There is marked thinning of the L4-5 intervertebral disc space level indicating degenerative disc disease. Some mild spurring projects from the anterior end-plates of L3 and L4 vertebral bodies indicating some mild degenerative disc disease. Some sclerotic change is present within the posterior articulating facets at the L4-5 and L5-S1 levels.

IMPRESSION:

1. At least a moderate degree of degenerative disc disease is noted at the L4-5 intervertebral disc level with mild degenerative disc changes noted at the L2-3 and L3-4 levels.
2. Some moderate degenerative change is present within the posterior articulating facets at the L4-5 and L5-S1 levels.

MRI B

Thank you for allowing us to examine your patient in our office.

TCS/tw
dict/trans 5/29/09

Terry C Shank MD
Terry C. Shank, MD Radiologist

6-3-09 LMOM JJR
6-3-09 Notified JJR

Final: Electronically signed by Jeffery Braham DO on 06/05/2009 at 2:57:40 pm

MID OHIO VALLEY MEDICAL GROUP
800 GRAND CENTRAL MALL
VIENNA, WV 26105-4131
(304) 485-3300

Print Date: 07/24/2009 2:58 pm

Order Status: **All Results Signed**
06/30/2009 9:54 pm

MARSHALL, ROBERT E
77 LITTLE ADDITION RD
DAVISVILLE, WV 26142

Patient ID/# 80652 **DOB** 05/08/1929 **Age** 80 years **Gender** Male
SSN: 233-44-6849
Home Phone (304) 422-2891
Work Phone (555) 555-5555 **Fasting** No

Ordering JEFFERY T BRAHAM DO | **Referring** | **Copy To**
Order # 226904 **Order Service Date** 06/12/2009 8:36 am **LIS Order Accession #**
Specimen Collection Date 06/19/2009 2:42 pm **Order Sent To LIS** 06/30/2009 2:42 pm
Order Comments
Test Ordered CT LUMBAR SPINE WITHOUT CONTRAST

TEST DESCRIPTION	RESULTS	REFERENCE RANGE	UNITS

CT LUMBAR SPINE WITHOUT CONTRAST

Test Ordered Date: 06/12/2009 8:36 am
Performing Lab: 3 Verified By:
CT SCAN
See attached image (#1) .

Test Status: Complete

Result Date/Status: 06/30/2009 2:42 pm F

FINAL: Electronically signed by Jeffery Braham DO on 06/30/2009 9:54 pm

Tests Performed At 3 RADIOLOGICAL TESTS Ph: (304) 485-3300 CLIA:
800 GRAND CENTRAL MALL
VIENNA, WV 26105

Result Status:
P = Preliminary F = Final CF = Corrected/Final
C = Corrected EIE = Entered In Error CP = Corrected/Preliminary

PatientID: 80652
Patient Name: ROBERT E MARSHALL
MRC Description: CT SCAN
Date of Birth: 05/08/1929
Date of Service: 06/19/2009

M

PARKERSBURG RADIOLOGY SERVICES, INC
800 Grand Central Mall Suite 7
Vienna, West Virginia 26105

W. Michael Hensley, MD Terry C. Shank, MD Kenneth T. Miller, MD
Bernard O. Garrett, DO Craig A. Chambers, DO

DATE: 6/19/09

Mid-Ohio Valley Medial Group
800 Grand Central Mall
Vienna, WV 26105

Jeffery T. Braham DO

NAME: Marshall, Robert E. 422-2891
ADDRESS: 77 Little Addition Road Davisville, WV

AGE: 5/8/29
X-RAY: 5829

REASON FOR EXAM: LOW BACK PAIN GOING INTO LEFT LEG

CT LUMBAR SPINE WITHOUT CONTRAST TO INCLUDE REFROMATS:
Multisliced scan was performed and 2 mm sagittal, 2 mm coronal and 3 mm axial images created. Mild-moderate convex left lower lumbar scoliosis is seen and no fracture, spondylolysis or spondylolisthesis is evident. The upper lumbar discs appear normal. There is moderate diffuse bulging of the L3-4 and L4-5 discs. The L5-S1 disc contour is normal, but there is a broad spur, which mildly narrows the left L5-S1 neural foramen. Facet degeneration is mild-moderate.

CONCLUSION:
1. Rotatory scoliosis is seen with moderate disc degenerative changes in the mid and lower lumbar spine, as described. No fracture, subluxation or focal disc protrusion is apparent.

Thank you for allowing us to review and interpret this study.

W Michael Hensley MD

WMH/js
dict/trans 6/22/09

W. Michael Hensley, MD Radiologist

6-26-09 Notified /GR He will call back if he wants P.T. set up/gr

PT
N

Final: Electronically signed by Jeffery Braham DO on 06/30/2009 at 9:54:18 PM

MID-OHIO VALLEY MEDICAL GROUP, INC.
800 GRAND CENTRAL MALL, SUITE 4
VIENNA, WV 26105
FAMILY PRACTICE 304/485-3300 PHONE 304/485-3317 FAX
UROLOGY DIVISION 304/485-7700 PHONE 304/485-5141 FAX

PatientID: 80652
Patient Name: ROBERT E MARSHALL
Date of Birth: 05/08/1929
Patient Age: 80 y

Date of Service: 05/12/2009

CHIEF COMPLAINT: Requested evaluation for the problem listed below.
HISTORY OF PRESENT ILLNESS:

HIP: Symptoms are localized to the left hip, pain radiates from the thigh to the knee, pain radiates into the lower leg and foot.states he fell in February 28th was seen at CCMH for fall lacerated head and hurt ribs. He did not know he had hurt his hip. He states pain has recently increased has difficulty lifting leg, tying shoes. Has been taking alieve and aspirin which upset his stomach. Was supposed to get tetanus shot did not get in ER.

PAST MEDICAL HISTORY:

MEDICAL: Type II Diabetes, hypertension, hypercholesterolemia.

CURRENT MEDICATION LIST:

STARLIX ORAL TABLET 120 MG, 1 po qac
ACTOS ORAL TABLET 45 MG, 1 Every Day
UNIVASC ORAL TABLET 15 MG, 1/2 Every Day
LIPITOR ORAL TABLET 20 MG, 1 Every Day
ATENOLOL ORAL TABLET 50 MG, 1 Every Day
METAGLIP ORAL TABLET 5-500 MG, 2 TWICE DAILY
ATROVENT NASAL SOLUTION 0.06 %, 2 SPRAYS Q 6H PRN
XANAX ORAL TABLET 0.5 MG, 1/2 TO 1 Q8H PRN

CURRENT ALLERGY LIST:

NKDA

SOCIAL HISTORY:

DIET: Follows no specific diet.

FAMILY HISTORY:

Not obtained.

REVIEW OF SYSTEMS:

GENERAL: Normal activity and energy level, no change in appetite. No major weight gain or loss. No malaise, chills, fever, diaphoresis.
CARDIAC: No chest pain, palpitations, tachyarrhythmia, orthopnea, dyspnea on exertion, or paroxysmal nocturnal dyspnea.
GI: No food intolerance, abdominal pain, nausea, vomiting, bloating, reflux, diarrhea, constipation, melena, or hematochezia. No change in caliber of stools.
GU: No penile discharge, lower tract obstructive symptoms, dysuria, or hematuria.
MUSCULOSKELETAL: See HISTORY OF PRESENT ILLNESS.
RESPIRATORY: No recent upper respiratory infections, dyspnea, cough, hemoptysis or wheezing.

PHYSICAL EXAMINATION:

CONSTITUTIONAL:

VITALS:

WEIGHT:220lbs

MID-OHIO VALLEY MEDICAL GROUP, INC.
800 GRAND CENTRAL MALL, SUITE 4
VIENNA, WV 26105
FAMILY PRACTICE 304/485-3300 PHONE 304/485-3317 FAX
UROLOGY DIVISION 304/485-7700 PHONE 304/485-5141 FAX

PatientID: 80652
Patient Name: ROBERT E MARSHALL
Date of Birth: 05/08/1929
Patient Age: 80 y

Date of Service: 05/12/2009

BLOOD PRESSURE:138/72 Left Arm Sitting

NECK AND THYROID: Symmetrical with no elevation of the jugular venous pulsation. Trachea midline. No thyroid enlargement, tenderness, or mass.
RESPIRATORY: Clear to auscultation. Normal respiratory effort.
CARDIOVASCULAR:
CARDIAC: Regular rate and rhythm.
ARTERIAL: Normal carotids.
MUSCULOSKELETAL EXAM:
EXTREMITIES:
LEFT LOWER: TENDER SCIATIC NOTCH, TROCHANTERIC BURSA TENDERNESS NOTED, REDUCED EXTERNAL ROTATION OF THE HIP, normal hip stability. has difficulty raising leg

ASSESSMENT/PLAN:
726.5-ENTHESOPATHY HIP REG left
MEDICATIONS:
ULTRAM ORAL TABLET 50 MG, 1 Every Six Hours, As Needed, 20 Dispensed, status: NEW PRESCRIPTION, 05/12/2009.
LAB ORDERS:
Order number: 217805 Test Ordered: X-RAY HIP LEFT
Order number: 217805 Test Ordered: X-RAY FEMUR LEFT
REFERRALS: Physical Therapist.
959.09-INJURY OF FACE AND NECK s/p suturing in March needs Td booster was not given in Er.
RETURN VISIT: Patient instructed to return in 2 weeks. The patient has a previous appointment.

Electronically Signed by: Lilia A. Underwood, FNP-BC on Monday, May 18, 2009 5:22 pm
Electronically Signed by: Jeffery Braham DO on Tuesday, May 19, 2009 8:18 pm

PLEASE SIGN AND FAX BACK TO 304-865-7400

1212 Garfield Avenue
Suite 200
Parkersburg, WV 26101

Mountain River PHYSICAL THERAPY

304-865-6778
Fax: 304-865-7400

EVALUATION

Patient Name:	Robert Marshall	**Date:**	05-19-09
Patient ID #:	10266	**Time In:**	
Patient DOB:	05-08-1929	**Time Out:**	
Diagnosis:	719.45 Pain joint (arthralgia): pelvic region/thigh	**Referred By:**	Lila Underwood NP

SUBJECTIVE:

Past Medical / Social History: Patient is an 80 year old male. Retired
PMH: diabetes, HTN, right knee arthroscopy, left shoulder RTC repair, hx of inguinal hernia sx.

Related Diagnostics / Medications: X-rays of hip, pelvis, and femur all negative.

History of Present Illness: Patient referred to physical therapy for left hip pain. Patient states he fell at the mall in February of this year. He has had left hip pain since. X-rays were negative. Patient c/o pain with bending of his left hip and left knee. He states having a limited walking tolerance due to fatigue, weakness, and pain. WB oin the left hip does not increase his pain as per patient although he primarily is WB right in standing. He states pain does not wake him at night. He c/o pain in his groin area and lateral hip area. He denies numbness/tingling or other radicular symptoms.

OBJECTIVE:

General Observations: Observation:
Posture is slightly flexed at the trunk and patient tends to stand with greater WB on the right side. He performs sit to stand and vice versa with decreased weight bearing left side.

Palpation:
Tenderness of the trochanteric area, glute med, anterior hip - hip flexor mm and quadriceps mid portion.

RECEIVED
MAY 29 2009

AROM Left knee:
-3 degrees extension to 111 degrees flexion and 118 degrees passive flexion

Hip Mobility:
left hip has pain with KTC and to approx 90-95 degrees with pain. Scours is positive for the left hip and FABER for anterior hip pain. ER is limited left and IR to some degree. Patient appears to be guarding with left hip ROM assessment. R hip ROM WNL.

LQ:
DTRs are 1= and symmetrical
No clonus observed
Sensory is intact

Strength:

left hip is 4/5 for flex/extension and 4-/5 abduction
left knee is 4/5 for flex/ext with pain in resited knee flexion
R hip and LE is 5/5 with MMT

Gait:
antalgic with note hip weakness in the abductors, left hip lacks extension.during gait.

Tests	Description	Results	Comments

ASSESSMENT:

Impression / Differentials: Left hip strain/injury from fall. Limited hip mobility and weakness. Left hip with signs of OA. X-rays negative. Bone scan may be appropriate if limite dprogress in therapy.

Therapy Problems
1. left hip pain with ambulaation and ADL function
2. left hip weakness
3. limited mobility of the left hip
4. STR/tenderness of the left hip

Goals:

Goal Term	Goal Description
1. Short-term	Decrease Pain
2.	Improve Soft Tissue Mobility
3.	Improve Joint Mobility - left hip and knee
4.	Improve Flexibility
5.	Tolerate Initiation of Strengthening Program
6. Long-term	AROM WFL without pain left hip
7.	LE MMT = 4+/5 for left hip and knee
8.	Zero to Trace Palpable Tenderness
9.	Zero to Trace Soft Tissue Restrictions
10.	ambulate for ADLs without pain.

TREATMENT PLAN: MT, TE, gait training, and modalities as needed

Consult with MD if minimal progress.

FREQUENCY & DURATION: 2 to 3 time(s) per week for 6 week(s).

Thank you for your referral!

Sincerely,

Ed Weber MPT

Edward G Weber MPT

RECEIVE
MAY 29 2009

Patient Name: Robert Marshall
Referring Physician: Lila Underwood NP

Dear Doctor,

Medicare guidelines require a physician signature approving the treatment plan every 30 days. Please sign and date the plan and return to our office. Thank you.

Julie Underwood FNP-BC 6/1/09

Physician Signature Date

RECEIVED

MAY 29 2009

MID-OHIO MEDICAL GROUP, INC.
610 WASHINGTON BOULEVARD STE 1
BELPRE, OH 45714
740/423-5055
740/423-5058 FAX

PatientID: 80652
Patient Name: ROBERT E MARSHALL
Date of Birth: 05/08/1929
Patient Age: @80 y

Date of Service: 05/27/2009

CHIEF COMPLAINT: Requested evaluation for the problem listed below.
PT C/O LEFT HIP PAIN THAT RADIATES INTO HIS LEFT LEG-HAS BEEN GOING ON FOR A WHILE HAS WENT TO PHYSICAL THERAPY X 3 TIMES
HISTORY:

250.00-DIABETES MELLITUS W/O COMPLIC TYP II The diabetes remains stable. The patient denies polyuria, polyphagia, polydipsia, change in vision, foot ulcerations, or hypoglycemic episodes. No complications noted from the medication presently being used.

272.2-HYPERLIPIDEMIA MIXED The patient's most recent LDL was not at goal. The patient is attempting to follow a low saturated fat diet. No complications noted from the medication presently being used.LAST LAB 12-18-08

401.1-ESSENTIAL HYPERTENSION BENIG The blood pressure readings taken outside the office since the last visit have been in the target range. The patient denies chest pain, shortness of breath, dyspnea on exertion, pedal edema, or headache. No complications noted from the medication presently being used.

PAST MEDICAL HISTORY:

MEDICAL: Type II Diabetes, hypertension, hypercholesterolemia.

CURRENT MEDICATION LIST:

STARLIX ORAL TABLET 120 MG, 1 po qac
ACTOS ORAL TABLET 45 MG, 1 Every Day
UNIVASC ORAL TABLET 15 MG, 1/2 Every Day
LIPITOR ORAL TABLET 20 MG, 1 Every Day
ATENOLOL ORAL TABLET 50 MG, 1 Every Day
METAGLIP ORAL TABLET 5-500 MG, 2 TWICE DAILY
ATROVENT NASAL SOLUTION 0.06 %, 2 SPRAYS Q 6H PRN
XANAX ORAL TABLET 0.5 MG, 1/2 TO 1 Q8H PRN
ULTRAM ORAL TABLET 50 MG, 1 Every Six Hours, As Needed

CURRENT ALLERGY LIST:

NKDA

SOCIAL HISTORY:

DIET: Follows no specific diet.

FAMILY HISTORY:

Not obtained.

REVIEW OF SYSTEMS:

GENERAL: Normal activity and energy level, no change in appetite. No major weight gain or loss. No malaise, chills, fever, diaphoresis.

CARDIAC: No chest pain, palpitations, tachyarrhythmia, orthopnea, dyspnea on exertion, or paroxysmal nocturnal dyspnea.

RESPIRATORY: No recent upper respiratory infections, dyspnea, cough, hemoptysis or wheezing.

PHYSICAL EXAMINATION:

MID-OHIO MEDICAL GROUP, INC.
610 WASHINGTON BOULEVARD STE 1
BELPRE, OH 45714
740/423-5055
740/423-5058 FAX

PatientID: 80652
Patient Name: ROBERT E MARSHALL
Date of Birth: 05/08/1929
Patient Age: @80 y

Date of Service: 05/27/2009

CONSTITUTIONAL:
VITALS:
WEIGHT:217lbs
BLOOD PRESSURE:126/87 Left Arm Sitting
PULSE:60 Right Radial, Regular

GENERAL APPEARANCE: Healthy appearing individual in no distress.
RESPIRATORY: Clear to auscultation. Normal respiratory effort.
CARDIOVASCULAR:
CARDIAC: Regular rate and rhythm.
ARTERIAL: Normal carotids.
ASSESSMENT/PLAN:
250.00-DIABETES MELLITUS W/O COMPLIC TYP II
ASSESSMENT: The diabetes remains satisfactory. Will check laboratory. Will not change medication, continue to monitor for complications.
272.2-HYPERLIPIDEMIA MIXED
ASSESSMENT: The patient's elevated cholesterol is stabilizing. Will not change medication, continue to monitor for complications. The patient is attempting to follow a low saturated fat diet. Will check laboratory.
401.1-ESSENTIAL HYPERTENSION BENIG
ASSESSMENT: The blood pressure remains satisfactory. Will not change medication, continue to monitor for complications. Patient is attempting to follow a low sodium diet. No laboratory work is necessary at this time.
847.1-THORACIC SPRAIN
STATUS: Unchanged.
LAB ORDERS:
Order number: 221911 Test Ordered: X-RAY LUMBAR SPINE

Electronically Signed by: Jeffery Braham DO on Wednesday, May 27, 2009 8:53 am

MOUNTAIN RIVER PHYSICAL THERAPY

63 Hospitality Lane, Suite 1
Mineral Wells, WV 26150
Phone: 304-489-8100
Fax: 304-489-8191

June 24, 2009

RE: *Robert Marshall*
DOB: 5/8/29

Lil Underwood, FNP, BC:

We have followed Robert Marshall in physical therapy for left hip pain.

Robert made good progress in therapy. Improvements made included increasing left hip strength to 4+/5 throughout. Improving left hip mobility for ADSL function, trace soft tissue restriction and tenderness. Mr. Marshall stated at d/c that he was pain free with his ADLs. He did c/o occasional feeling of stiffness.

Mr. Marshall was d/c on 6/12/09. He was instructed to continue with his home program. Thank you for this referral.

Sincerely,

Ed Weber, MPT

Ed Weber, MPT

Mountain RIVER
PHYSICAL THERAPY

www.mountainriverpt.com

PARKERSBURG RADIOLOGY SERVICES, INC
800 Grand Central Mall Suite 7
Vienna, West Virginia 26105

W. Michael Hensley, MD Terry C. Shank, MD Kenneth T. Miller, MD
Bernard O. Garrett, DO Craig A. Chambers, DO

DATE: 3/2/09

Jeffery T. Braham DO Tammy Crookshanks FNP-BC
Mid-Ohio Valley Medical
800 Grand Central Mall
Vienna, WV 26105

NAME: Marshall, Robert E. AGE: 5/8/29
ADDRESS: 77 Little Addition Road Davisville, WV X-RAY: C1188

REASON FOR EXAM: PAIN LOW LEFT LATERAL AND ANTERIOR RIBS

PA CHEST AND LEFT RIBS:
A total of five views of the chest and left ribs are submitted for interpretation. The chest radiograph shows the heart to be enlarged. There are some linear densities in each base. This is greater on the left, suggestive of some atelectasis and/or scarring. The images of the ribs demonstrate no evidence of a displaced fracture.

IMPRESSION:
1. Mild cardiomegaly and some chronic appearing interstitial changes are seen. There is also some patchy density in the bases, some underlying atelectasis or faint infiltrate cannot be excluded.
2. No evidence of a displaced rib fracture is identified.

Thank you for allowing us to examine your patient in our office.

CAC/jw
dict/trans 3/3/09

Craig A. Chambers, D.O., Radiologist

PARKERSBURG RADIOLOGY SERVICES, INC
800 Grand Central Mall Suite 7
Vienna, West Virginia 26105

W. Michael Hensley, MD Terry C. Shank, MD Kenneth T. Miller, MD
Bernard O. Garrett, DO Craig A. Chambers, DO

DATE: 6/19/09

Mid-Ohio Valley Medial Group
800 Grand Central Mall
Vienna, WV 26105

Jeffery T. Braham DO

NAME: Marshall, Robert E. AGE: 5/8/29
ADDRESS: 77 Little Addition Road Davisville, WV X-RAY: 5829

REASON FOR EXAM: LOW BACK PAIN GOING INTO LEFT LEG

CT LUMBAR SPINE WITHOUT CONTRAST TO INCLUDE REFROMATS:
Multisliced scan was performed and 2 mm sagittal, 2 mm coronal and 3 mm axial images created. Mild-moderate convex left lower lumbar scoliosis is seen and no fracture, spondylolysis or spondylolisthesis is evident. The upper lumbar discs appear normal. There is moderate diffuse bulging of the L3-4 and L4-5 discs. The L5-S1 disc contour is normal, but there is a broad spur, which mildly narrows the left L5-S1 neural foramen. Facet degeneration is mild-moderate.

CONCLUSION:

1. Rotatory scoliosis is seen with moderate disc degenerative changes in the mid and lower lumbar spine, as described. No fracture, subluxation or focal disc protrusion is apparent.

Thank you for allowing us to review and interpret this study.

W Michael Hensley M.D.

WMH/js
dict/trans 6/22/09

W. Michael Hensley, MD Radiologist

~ PARKERSBURG RADIOLOGY SERVICES, INC.
~ 800 Grand Central Mall Suite 7
~ Vienna, WV 26105

W. Michael Hensley, MD Terry C. Shank, MD Kenneth T Miller, MD
Bernard O. Garrett, DO ~ Craig A. Chambers, DO

~ DATE 5/12/09

Jeffery T Braham DO
Mid-Ohio Valley Medical Group ~ Lilia Underwood FNPBC~
800 Grand Central Ave
Vienna, WV 26105

NAME Marshall, Robert E ~ ABE 5/0/29

ADDRESS 77 Little Add Rd Davisville WV ~ X-RAY C2896

REASON FOR EXAM: Fell. Pain.

PELVIS AND LEFT HIP:
Examination of the pelvic structures fails to show a fracture or definite abnormality. No definite fractures are seen about the pubic rami. Examination of the hip fails to show a fracture, dislocation or definite abnormality.

IMPRESSION:
1. Negative examination of the pelvis and left hip.

LEFT FEMUR - TWO VIEWS:
AP and lateral views were obtained and demonstrate no acute or healing fracture or other abnormality.

CONCLUSION:
1. No fracture identified.

Thank you for allowing us to examine your patient in our office.

W Michael Hensley MD

WMH/tw
dict/trans 05/13/09 ~ W. Michael Hensley, MD Radiologist

PARKERSBURG RADIOLOGY SERVICES, INC
800 Grand Central Mall Suite 7
Vienna, West Virginia 26105

W. Michael Hensley, MD Terry C. Shank, MD Kenneth T. Miller, MD
Bernard O. Garrett, DO Craig A. Chambers, DO

DATE: 5/28/09

Mid Ohio Valley Medical Group
800 Grand Central Mall
Vienna, WV 26105

Jeffery Braham DO

NAME: Marshall, Robert E AGE: 5/8/29
ADDRESS: 77 Little Add Rd Davisville WV X-RAY: C-3279

REASON FOR EXAM: Pain left hip and down leg. Fell in February.

LUMBAR SPINE –THREE VIEWS:
AP, lateral and spot projection of the lumbosacral junction were obtained.

The lumbar vertebral body heights are well maintained.

There is marked thinning of the L4-5 intervertebral disc space level indicating degenerative disc disease. Some mild spurring projects from the anterior end-plates of L3 and L4 vertebral bodies indicating some mild degenerative disc disease. Some sclerotic change is present within the posterior articulating facets at the L4-5 and L5-S1 levels.

IMPRESSION:

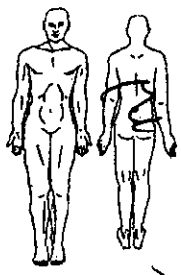
1. At least a moderate degree of degenerative disc disease is noted at the L4-5 intervertebral disc level with mild degenerative disc changes noted at the L2-3 and L3-4 levels.
2. Some moderate degenerative change is present within the posterior articulating facets at the L4-5 and L5-S1 levels.

Thank you for allowing us to examine your patient in our office.

TCS/tw
dict/trans 5/29/09

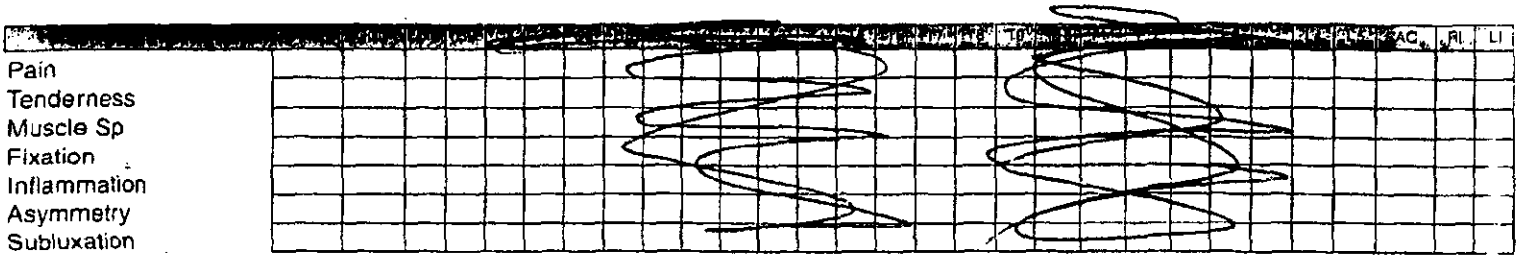
Terry C. Shank, MD Radiologist

Date APR 17 2009 Name H. Marshall ☐ New Injury ☐ Reoccurrence



Pain 1 2 3 4 5 6 7 8 9 10

Chief Complaint: Acute Chronic Cervical Dorsal Lumbar Pelvis Pain
w/ rad pain L B R Shoulder Arm Hand Hip Leg Foot Head Ribs Other
Numbness L B R Shoulder Arm Hand Hip Leg Foot Head Ribs Other
DOI 2 days DOC _____ DWMY Worse _____ DWM _____
MOI: Lifting Fall ADL's A/A Work Other _____
Pain is: Sharp Dull Ache Stabbing Burning Constant Intermediate
Better with: Rest Activity Ice Heat Rx _____
Worse with: Activity Sitting Standing Bending Raising Laying
Prior TX: Chiro Yes P.T. _____ Rx _____ MD _____
Notes/ secondary complaint: _____



Pain
Tenderness
Muscle Sp
Fixation
Inflammation
Asymmetry
Subluxation
☐ See other exam

Neuro: Unremarkable _____
Ortho: Unremarkable _____
Notes: _____

Diagnosis 847.0 ~~847.1 847.2~~ 846.0 846.1 723.4 cer rad 724.4 thor rad 724.3 sciatica
739.1 ~~739.2 739.3~~ 739.4 739.5 840.9 843.9 844.9 other _____
Initial prog. ~~Good~~ Fair Poor Guarded ☐ pt Off work _____
TX Plan 2 tx for 2 wks ☐ pt Light Duty _____
2 tx for 2 wks ☐ pt Restricted ADS's _____
Chiro manipulation to Cervical Dorsal Lumbar Pelvic
EMS- 15 mins Heat- 15 mins Cold- 15 mins U/S- 15 mins
Treatment Goal ☐↓ Pain ☐↓ Numbness ☐↑ ADL's ☐↑ ROM
Objective Measure ☐↓ Tenderness ☐↓ Muscle spasm ☐↓ Fixation ☐↓ Inflammation ☐↓ ASY

Date _____ ☐ PT Reports _____ % in CC ☐ PT Reports temp relief
☐ PT Reports no change ☐ PT Reports Slight ↑ in C.C. ☐ PT is worse
☐ PT Reports new complaint _____ ☐ PT Reports exacerbation _____
Notes: _____

Tenderness			Muscle Sp			Fixation			Inflammation			Asymmetry		
C ☐↓	☐S	☐↑	C ☐↓	☐S	☐↑	C ☐↓	☐S	☐↑	C ☐↓	☐S	☐↑	C ☐↓	☐S	☐↑
D ☐↓	☐S	☐↑	D ☐↓	☐S	☐↑	D ☐↓	☐S	☐↑	D ☐↓	☐S	☐↑	D ☐↓	☐S	☐↑
L ☐↓	☐S	☐↑	L ☐↓	☐S	☐↑	L ☐↓	☐S	☐↑	L ☐↓	☐S	☐↑	L ☐↓	☐S	☐↑
P ☐↓	☐S	☐↑	P ☐↓	☐S	☐↑	P ☐↓	☐S	☐↑	P ☐↓	☐S	☐↑	P ☐↓	☐S	☐↑
Other			Other			Other			Other			Other		

☐ Pt is responding to care ☐ PT is responding slow ☐ PT is responding fast ☐ no response
☐ Continue as planned ☐ change plan ☐ ↑ visit # ☐ ↓ visit # ☐ ↑ duration ☐ ↓ duration
☐ X Ray _____ ☐ MRI _____ ☐ Refer Pt _____ ☐ Home Exercise
☐ Release from care ☐ Return as needed ☐ Discontinue Treatment
☐ Re-examine Patient ☐ Return _____ for follow-up

Chiro manipulation to: Cervical Dorsal Lumbar Pelvic
EMS- 15 mins Heat- 15 mins Cold- 15 mins U/S- 15 mins

Notes: _____

JUL-31-2009 01:21P FROM: ID: 13044851050 P.3/3

5-17-02

Robert Marshall **PATIENT RECORD** "duplicate" **ACCOUNT**

Date	Spinal Manipulation	Therapy	Treatment	Chg.	Paid	Bal.
MAY 1 5	☑ Cervical ☑ Thoracic ☑ Lumbar	☐ Heat ☐ Ice ☑ LV ☐		25	mc	25
MAY 2 0 2002	☑ Cervical ☑ Thoracic ☑ Lumbar	☐ Heat ☐ Ice ☑ LV ☐		25	mc	50
7/9/02	☐ Cervical ☐ Thoracic ☐ Lumbar	☐ Heat ☐ Ice ☐ LV ☐	mc pd. 5/15/02 - 5/20/02	(50)	38 20	Ø
8 28-02	☐ Cervical ☐ Thoracic ☐ Lumbar	☐ Heat ☐ Ice ☐ LV ☐	Ins pd. 5/15/02 - 5/20/02		9.56	0
FEB 1	☑ Cervical ☑ Thoracic ☑ Lumbar	☐ Heat ☐ Ice ☑ LV ☐		15	15	
APR 1 7 2009	☑ Cervical ☑ Thoracic ☐ Lumbar	☑ Heat ☑ Ice ☐ LV ☐		35	20	15
5/6/09	☐ Cervical ☐ Thoracic ☐ Lumbar	☐ Heat ☐ Ice ☐ LV ☐	billed 4/17/09			15
6/8/09	☐ Cervical ☐ Thoracic ☐ Lumbar	☐ Heat ☐ Ice ☐ LV ☐	ins Pd. 4/17/09	(35)	32 28	+20
6/8/9	☑ Cervical ☐ Thoracic ☐ Lumbar	☐ Heat ☐ Ice ☐ LV ☐	pt refund		20	0
	☐ Cervical ☐ Thoracic ☐ Lumbar	☐ Heat ☐ Ice ☐ LV ☐				
	☐ Cervical ☐ Thoracic ☐ Lumbar	☐ Heat ☐ Ice ☐ LV ☐				
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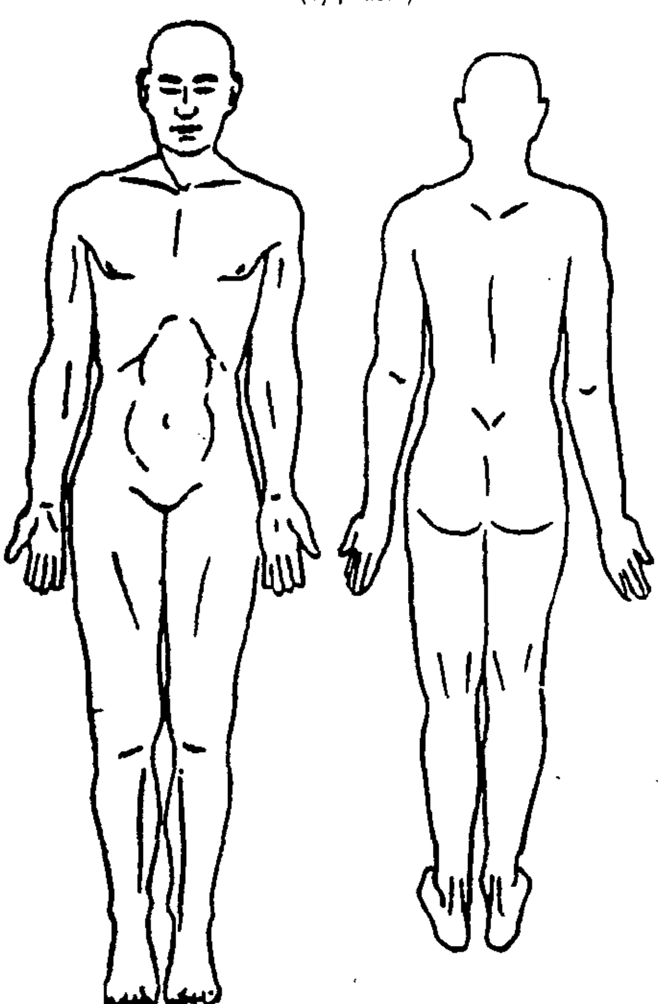
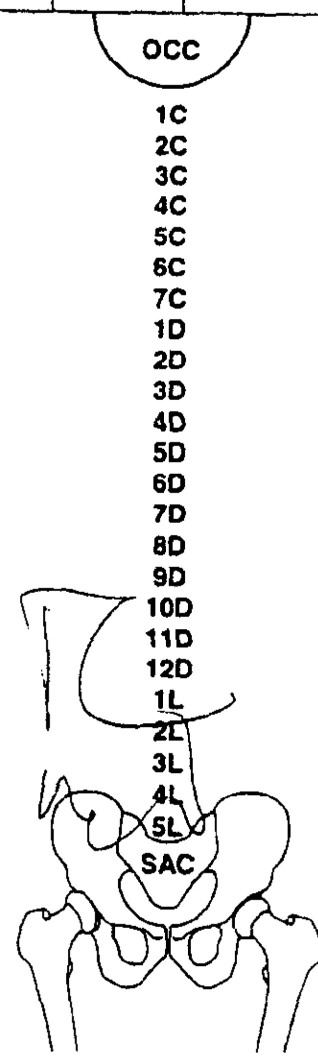
	☐ Cervical ☐ Thoracic ☐ Lumbar	☐ Heat ☐ Ice ☐ LV ☐				
	☐ Cervical ☐ Thoracic ☐ Lumbar	☐ Heat ☐ Ice ☐ LV ☐				

MARK AREA OF PAIN
(by patient)



Date	Subsequent Complaints
	Xrays @ CCMH
	will call c date.
	MC# 233-44-6849A.
	XR - 8/24/01
1/1/03	ent. into new MC program

OCC - Occiput
C - Cervical Vertebrae
D - Dorsal Vertebrae
L - Lumbar Vertebrae
SAC - Sacrum



SPINAL ANALYSIS

GEORGE J. COSENZA, PLLC

Admitted In West Virginia and Ohio

ATTORNEY AT LAW

515 Market Street Post Office Box 4
Parkersburg, West Virginia 26102
e-mail: cosenza@wvdsl.net

(304) 485-0990
Fax (304) 485-1090

July 17, 2009

Mountain River Physical Therapy
63 Hospitality Lane, Suite 1
Mineral Wells, WV 26150

Re: Robert E. Marshall
DOB: 5/08/29
SSN: 273-44-6849

Dear Sir or Madam:

I represent the interests of Robert E. Marshall. Mr. Marshall has requested that I obtain copies of all of his medical records currently in your possession concerning your treatment of him for injuries suffered in a fall on February 23, 2009. I have enclosed the appropriate authorization forms for same. In addition, I would appreciate you providing me with **AN ITEMIZED STATEMENT INDICATING ALL CHARGES FOR SERVICES RENDERED**. Please provide this information to my office as soon as possible. If there are any costs for these documents, please contact me or include a statement for the amount due with the records, and I will reimburse you for same upon receipt of the package.

Thank you for your cooperation in this matter. If you have any questions, please do not hesitate to contact me.

Very truly yours,

George J. Cosenza

George J. Cosenza

GJC/tap
Enclosure

cc: Robert E. Marshall

Month. Stat

MOUNTAIN RIVER PHYSICAL THERAPY

Auth # _____ _____ _____ _____ Advantra Freedom
Visits Auth _____ _____ _____ _____ 20 MT tx
Exp. Date_____ _____ _____ _____ _____

Signature	Date	Signature	Date
1. Robert E. Marshall	5-19-09	26.	
2. Robert Marshall	5.20.09	27.	
3. Robt Marshall	5.22.09	28.	
4. Robt Marshall	5.27.09	29.	
5. Robert Marshall	5.29.09	30.	
6. Robert Marshall	6.2.09	31.	
7. Robert Marshall	6.4.09	32.	
8. Robert Marshall	6.9.09	33.	
9. Robert Marshall	6-12-09	34.	
10.		35.	
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19.		44.	
20.		45.	
21.		46.	
22.		47.	
23.		48.	
24.		49.	
25.		50.	

Parkersburg
1212 Garfield Ave., Suite 200
Parkersburg, WV 26101
Ph: 304-865-6778
Fx: 304-865-7400

Mineral Wells
63 Hospitality Lane, Suite 1
Mineral Wells, WV 26150
Ph: 304-489-8100
Fx: 304-489-8191

Vienna
800 Grand Central Mall
Suite 1
Vienna, WV 26105
Ph: 304-865-6777
Fx: 304-865-6780

Mountain River PHYSICAL THERAPY

PATIENT: Robert Marshall

DIAGNOSIS: Lt hip pain - Strengthening training

TYPE/DATE OF SURGERY: ________

[X] ***EVALUATE AND TREAT***

____ Daily for __ days ____ 1xWK ____ 2xWK ____ 3xWK for ___ Weeks.

- ☐ ***MANUAL THERAPY***
- ☐ Joint Mobilization
- ☐ Soft Tissue Mobilization
- ☐ Spinal Stabilization
- ☐ Myofascial Release

- ☐ ***MODALITIES***
- ☐ Electrical Stimulation
- ☐ Phonophoresis / Iontophoresis
- ☐ Ultrasound

- ☐ THERAPEUTIC EXERCISE
- ☐ TRACTION
- ☐ GAIT TRAINING
- ☐ TENS APPLICATION
- ☐ WORK CONDITIONING
- ☐ WORK HARDENING
- ☐ FUNCTIONAL CAPACITY EVALUATION
- ☐ HOME PROGRAM INSTRUCTIONS

- ☐ ***ORTHOTICS***
- ☐ Temporary
- ☐ Permanent

Other: ________

Referring Physician: [illegible] FNP BC Date: 5/4/07

left hip is 4/5 for flex/extension and 4-/5 abduction
left knee is 4/5 for flex/ext with pain in resited knee flexion
R hip and LE is 5/5 with MMT

Gait:
antalgic with note hip weakness in the abductors, left hip lacks extension.during gait.

Tests	Description	Results	Comments

ASSESSMENT:

Impression / Differentials: Left hip strain/injury from fall. Limited hip mobility and weakness. Left hip with signs of OA. X-rays negative. Bone scan may be appropriate if limite dprogress in therapy.

Therapy Problems
1. left hip pain with ambulaation and ADL function
2. left hip weakness
3. limited mobility of the left hip
4. STR/tenderness of the left hip

Goals:

Goal Term	Goal Description
1. Short-term	Decrease Pain
2.	Improve Soft Tissue Mobility
3.	Improve Joint Mobility - left hip and knee
4.	Improve Flexibility
5.	Tolerate Initiation of Strengthening Program
6. Long-term	AROM WFL without pain left hip
7.	LE MMT = 4+/5 for left hip and knee
8.	Zero to Trace Palpable Tenderness
9.	Zero to Trace Soft Tissue Restrictions
10.	ambulate for ADLs without pain.

TREATMENT PLAN: MT, TE, gait training, and modalities as needed

Consult with MD if minimal progress.

FREQUENCY & DURATION: 2 to 3 time(s) per week for 6 week(s).

Thank you for your referral!

Sincerely,

Ed Weber MPT

Edward G Weber MPT

RECEIVE

MAY 2 8

Patient Name: Robert Marshall
Referring Physician: Lila Underwood NP

Dear Doctor,

Medicare guidelines require a physician signature approving the treatment plan every 30 days. Please sign and date the plan and return to our office. Thank you.

Physician Signature

6/1/09
Date

MOU AIN RIVER PHYSICAL THE APY

Patient Information Form (please print neatly)

Today's Date: 5-19-09 P.T.: _____

Referring Dr Lil Underwood / Braham Dr Ph#: _____

Date of onset/injury: _____ Diag: _____

Work related: [ ] Yes [✓] No if yes; State _____ Claim# _____ DOI _____

MVA or Personal Injury: [ ] Yes [✓] No If yes; Attorney's Name: _____

Are you currently receiving Home Health Care? NO

PATIENT INFORMATION

Patient's Full Name: Robert E. Marshall Home Ph# 304-422-2891

Street Address: 77 LITTLE ADD. RD. Work Ph# _____

City, State, Zip DAVISVILLE, WV. 26142

Birth date: 5-8-29 SS#: 233-44-6849 [✓] Male [ ] Female

Employer & Address: RET.

HEALTH INSURANCE INFORMATION

Insurance Company Name: Advantra Freedom

Address: _____ Phone# _____

Policy Holder's Name: _____ Policy Holder Birth date: _____

Policy holder's SS#: _____ Relationship to patient: _____

Policy/ID# _____ Group# _____

If there is a secondary insurance, complete the following:

Insurance Company Name: _____

Address: _____ Phone# _____

Policy Holder's Name: _____ Policy Holder Birth date: _____

Policy holder's SS#: _____ Relationship to patient: _____

Policy/ID# _____ Group# _____

Robert E. Marshall

Signature of Patient or authorized person's signature (parent, legal guardian, etc)

Revised July 2008
Reviewed Nov 2008

PATIENT MEDICAL HISTORY **MOUNTAIN RIVER PHYSICAL THERAPY**

LAST NAME: MARSHAL **FIRST NAME:** ROBERT
AGE: 60 **HEIGHT:** 5'7 **WEIGHT:** 215 **REFERRING PHYSICIAN:** BRAHAM
EMPLOYER: RET **OCCUPATION:** _____
ARE YOU CURRENTLY WORKING? YES NO ✓ **IF NO, SINCE WHEN?** _____

NEXT APPOINTMENT WITH PHYSICIAN? 5-27-09

PLEASE MARK THE FOLLOWING IF YOU HAVE HAD:

___ ANGINA	___ HEART ATTACKS
___ STROKES	___ HEART SURGERY
___ TUMORS	✓ DIABETES
___ EPILEPSY	___ GASTROINTESTINAL PROBLEMS
___ ALLERGIES	___ CIRCULATORY PROBLEMS
___ OSTEOPOROSIS	___ NERVOUS OR EMOTIONAL PROBLEMS
___ KIDNEY DISEASE	___ GOUT
___ NECK INJURIES	✓ FRACTURES (BROKEN BONES)
___ BACK INJURIES	___ DISLOCATIONS (JOINTS)
___ WHIPLASH	___ HEART DISEASE
___ CANCER	✓ HIGH BLOOD PRESSURE
___ LUNG DISEASE	___ ALCOHOL ABUSE PROBLEMS
___ ARTHRITIS	___ JAW INJURIES/TMJ
✓ JOINT SPRAINS	✓ MUSCLE STRAINS

CHECK THE FOLLOWING BOXES IF YOU HAVE RECENTLY EXPERIENCED:

___ HEADACHES	✓ MUSCULAR PAIN WITH EXERTION
✓ FALLS	___ MUSCULAR PAIN AT REST
___ DIFFICULTY SLEEPING	___ CONSTANT PAIN UNRELIEVED BY REST OR MOVEMENT
___ TREMORS	___ CHANGE IN BOWEL OR BLADDER HABITS
___ BALANCE PROBLEMS	___ UNUSUAL FATIGUE OR WEAKNESS
✓ BLURRED/DOUBLE VISION	___ UNUSUAL SKIN COLORATION
___ DIZZINESS	___ UNEXPLAINED WEIGHT LOSS
___ SHORTNESS OF BREATH	___ TINGLING, NUMBNESS, OR LOSS OF FEELING
✓ HOARSENESS	✓ PAIN WITH COUGHING OR SNEEZING

PLEASE LIST ANY MAJOR SURGERIES AND HOSPITALIZATIONS

RIGHT KNEE DATE: ?
LEFT SHOULDER DATE: ?
_____ DATE: ?

DO YOU SMOKE? YES NO ✓ **IF YES, HOW MANY PACKS PER DAY?**

ARE YOU PREGNANT? YES NO

ARE YOU ALLERGIC TO ANY MEDICATION? YES NO ✓ **IF YES, PLEASE LIST MEDICATIONS.**

PLEASE LIST ALL MEDICATIONS YOU ARE PRESENTLY TAKING:

PLEASE MARK THE FOLLOWING IF ANY OF THESE DIAGNOSTIC TESTS HAVE BEEN PERFORMED?

✓	X-RAYS	DATE:_____	RESULTS:	GOOD	
___	MRI	DATE:_____	RESULTS:_____		
___	CAT SCAN	DATE:_____	RESULTS:_____		
___	EMG/NCV	DATE:_____	RESULTS:_____		

DATE OF ONSET OF PAIN? FED - 12-28-09 **WAS IT DUE TO AN INJURY?** (YES) NO

IS THIS PROBLEM WORK RELATED? YES NO **MOTOR VEHICLE ACCIDENT?** YES NO

PLEASE DESCRIBE YOUR PROBLEM

LEFT HIP.
RIGHT SHOULDER

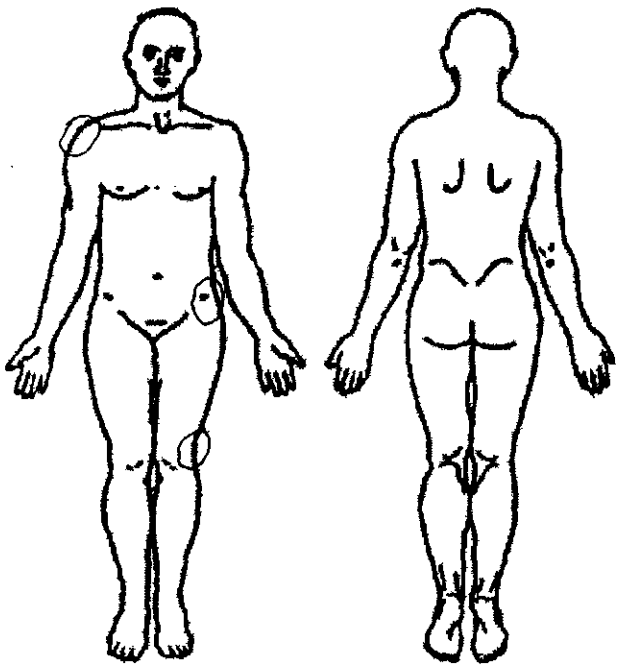
PLEASE CHECK THE FOLLOWING WHICH BEST DESCRIBE YOUR PAIN

___ CONSTANT	___ INCREASING	___ NIGHT PAIN	___ DULL/ACHY PAIN
___ INTERMITTENT	___ DECREASING	✓ STIFFNESS	___ PAIN UPON WAKING
✓ OCCASIONAL	___ STATIC	___ SHARP PAIN	

PAIN IS **AGGRAVATED** BY: BENDING = LEFT LEG - HIP
PAIN IS **EASED** BY:_____
HAVE YOU BEEN TREATED BY A **PHYSICAL THERAPIST**? YES NO **CHIROPRACTOR** (YES) NO
IF YES, APPROXIMATE DATE: APRIL 09?

WHAT WERE YOU TREATED FOR?_____

PLEASE CIRCLE THE AREA THAT HURTS



I, THE UNDERSIGNED, STATE THAT I HAVE ANSWERED THIS QUESTIONAIRE TO THE BEST OF MY KNOWLEDGE.

Robert E. Marshall 5-19-09
SIGNATURE **DATE**

~MOUNTAIN RIVER PHYSICAL THERAPY FINANCIAL POLICY~

We are committed to provide you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our ***Financial Policy*** is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility.

All patients must complete our ***Patient Information, Medical History, and Financial Policy*** forms before being treated.

REGARDING INSURANCE: Insurance is a contract between you and your insurance carrier. **We strongly encourage you to contact your insurance carrier to determine what coverage they provide for physical therapy.** We cannot guarantee what your insurance carrier will pay. We file insurance claims as a courtesy to our patients. You must provide all necessary information for us to assist you with your billing. We will not become involved in disputes between you and your insurance carrier regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary. You are responsible for the timely payment of your account.

HMO/PPO/POS: If you are covered by any of these, your co-payment is due at the time of service.

MEDICARE: We are providers for Medicare, and we will take the responsibility of submitting your claim for you. We will bill your secondary insurance if applicable. However, you are responsible for the deductible if it is has not been met at the time of service, and the co-insurance if there is no secondary insurance.

AUTO ACCIDENTS AND PERSONAL INJURY: If you have been injured due to a motor vehicle accident or from personal injury, please inform us upon registration. Arrangements must be made with the billing department regarding your account.

We accept payment by **cash, check, Visa, or MasterCard**.

I understand and accept the conditions of this financial policy.

Signature: Robert E Marshall Date: 5-19-09

Revised July 2008
Reviewed Nov 2008

General Office Information

Welcome to Mountain River Physical Therapy. We look forward to serving your physical therapy needs and wish you a speedy recovery.

Cancellation Policy: Appointment times are reserved exclusively for you. If you are unable to keep your appointment, we request twenty-four hours notice to allow us time to offer that appointment to someone else.

We do understand that extenuating circumstances sometimes occur for missing appointments and should be discussed with the office manager.

Authorization For Release: I hereby authorize Mountain River Physical Therapy to release any information concerning my care to the appropriate individuals of insurance companies and physicians. I accept full responsibility for any deductibles and co-insurance, or any amount not covered by my insurance company for service rendered to me by this facility. I authorize payment of medical benefits to Mountain River Physical Therapy.

Treatment Consent Authorization: I am fully aware of my medical diagnosis and I give my consent to Mountain River Physical Therapy to provide treatment for my condition.

Medicare Signature on File: I authorize payment of my Medicare Benefits to Mountain River Physical Therapy for services rendered.

Primary/Secondary Insurance Signature on File: I authorize payments of my medical benefits to Mountain River Physical Therapy for services rendered.

Notice of Privacy Practices: I have received a copy of Mountain River Physical Therapy's Notice of Privacy Practices.

Signature: Robert E. Marshall **Date:** 5-19-09

Rev. Pa

5-19
1:00
Ed.

Mountain RIVER PHYSICAL THERAPY

New Patient Verification Form

Today's Date 5.14.09

Patient's Name Robert Marshall Date of Appointment 5.19.09

Referring Physician: Underwood Therapist Name: Ed

Diagnosis: hip pain Surgery Date:

* *

Insurance Name: Advantra Freedom 80127599301 DOB: 5-8-29

Insurance Representative's Name Amenka

Ask for the address to send claims to: PO Box 7154

London, KY 40742-7154

Limit on Units/Modalities Per Day? –

Limit on CPT Codes? –

Co-Pay Apply to Eval/Re-Eval Every DOS? –

Do you show us being an in-network provider? yes

Authorization Needed? – Authorization # –

Pre-Cert Needed – Expiration Date: Jan - Dec

PCP Referral Needed? – Co-Pay/Percent 100% ($20.00)

Effective Date 7-1-07 Deductible/Out of Pocket – / 500.00

Did this pt have prior PT visit?

Additional Instructions: 20tx MT / MCare guidelines - No Cap.
Cannot tell about home health.

THIS IS NOT A GUARANTEE OF COVERAGE, BENEFITS or PAYMENT

You should also check your benefits with your insurance company

Patient Signature: Robert Marshall Date: 5-19-09 Verified By: J. Beeson

Revised Nov 2008

811 301-7330

Advantra Freedom
from Coventry Health Care

Public Employees Insurance Agency

Plan Type: Medicare Advantage Private Fee For Service
Name: ROBERT E MARSHALL
ID#: 80127599301
Issuer: 80840
Group#: 7604300440
Group: PEIA

RxBIN: 610014
RxPCN: MEDDPRIME
RxGrp: CVTYMED

Primary Care Office Visit Co-payment: OUT$10 ER: $50
Specialist Office Visit Co-payment: $20
Providers may call for terms and conditions or to confirm enrollment.
See back of card. **CMS-H5227-802**

MedicareRx
Prescription Drug Coverage

medco
Part B RxGrp: CVTYMEB

Customer Service: 1-877-337-4178, TDD: 1-866-386-2335,
M-F, 8:00 a.m. – 10:00 p.m., Eastern Standard Time
Nurse Information Line: Call 1-800-765-7197
TDD: Call your state relay number.
Hours of operation: 24 hours/ 7 days a week.
Provider Services: 1-800-713-5095, TDD: 1-866-386-2335
Submit claims to: P.O. Box 7154 , London, KY 40742
Electronic Payer ID: 25152
DO NOT bill Original Medicare.
Medicare limiting charges apply.
Send Pharmacy Claims to:
Medco PO Box 14724, Lexington, KY 40512
Pharmacy Customer Service: 1-888-816-7671
TDD: 1-800-716-3231, 24 hours/7 days a week
Pharmacy Provider Line: 1-800-922-1557

www.advantrafreedom.com
This card is for both medical and prescription benefits.

MOUNTAIN RIVER PHYSICAL THERAPY

63 Hospitality Lane, Suite 1
Mineral Wells, WV 26150
Phone: 304-489-8100
Fax: 304-489-8191

June 24, 2009

RE: Robert Marshall
DOB: 5/8/29

Lil Underwood, FNP, BC:

We have followed Robert Marshall in physical therapy for left hip pain.

Robert made good progress in therapy. Improvements made included increasing left hip strength to 4+/5 throughout. Improving left hip mobility for ADSL function, trace soft tissue restriction and tenderness. Mr. Marshall stated at d/c that he was pain free with his ADLs. He did c/o occasional feeling of stiffness.

Mr. Marshall was d/c on 6/12/09. He was instructed to continue with his home program. Thank you for this referral.

Sincerely,

Ed Weber, MPT

Ed Weber, MPT

MID-OHIO VALLEY MEDICAL GROUP, INC.
800 GRAND CENTRAL MALL, SUITE 4
VIENNA, WV 26105
FAMILY PRACTICE 304/485-3300 PHONE 304/485-3317 FAX
UROLOGY DIVISION 304/485-7700 PHONE 304/485-5141 FAX

PatientID: 80652
Patient Name: ROBERT E MARSHALL
Date of Birth: 05/08/1929
Patient Age: 80 y

Date of Service: 05/13/2009

May 13, 2009

Robert Marshall
77 Little Addition Rd
Davisville, WV 26142

Dear Mr. Marshall:

This is a brief letter to relay the results of your recent tests.

The x-ray of your pelvis, left hip and femur report as negative results.
If pain persist will need to follow up with your doctor.

Sincerely,

Lilia Underwood, CFNP.

1212 Garfield Avenue
Suite 200
Parkersburg, WV 26101

Mountain River PHYSICAL THERAPY

304-865-6778
Fax: 304-865-7400

EVALUATION

Patient Name:	Robert Marshall	**Date:**	05-19-09
Patient ID #:	10266	**Time In:**	
Patient DOB:	05-08-1929	**Time Out:**	
Diagnosis:	719.45 Pain joint (arthralgia): pelvic region/thigh	**Referred By:**	Lila Underwood NP

SUBJECTIVE:

Past Medical / Social History: Patient is an 80 year old male. Retired
PMH: diabetes, HTN, right knee arthroscopy, left shoulder RTC repair, hx of inguinal hernia sx.

Related Diagnostics / Medications: X-rays of hip, pelvis, and femur all negative.

History of Present Illness: Patient referred to physical therapy for left hip pain. Patient states he fell at the mall in February of this year. He has had left hip pain since. X-rays were negative. Patient c/o pain with bending of his left hip and left knee. He states having a limited walking tolerance due to fatigue, weakness, and pain. WB oin the left hip does not increase his pain as per patient although he primarily is WB right in standing. He states pain does not wake him at night. He c/o pain in his groin area and lateral hip area. He denies numbness/tingling or other radicular symptoms.

OBJECTIVE:

General Observations: Observation:
Posture is slightly flexed at the trunk and patient tends to stand with greater WB on the right side. He performs sit to stand and vice versa with decreased weight bearing left side.

Palpation:
Tenderness of the trochanteric area, glute med, anterior hip - hip flexor mm and quadriceps mid portion.

AROM Left knee:
-3 degrees extension to 111 degrees flexion and 118 degrees passive flexion

Hip Mobility:
left hip has pain with KTC and to approx 90-95 degrees with pain. Scours is positive for the left hip and FABER for anterior hip pain. ER is limited left and IR to some degree. Patient appears to be guarding with left hip ROM assessment. R hip ROM WNL.

LQ:
DTRs are 1= and symmetrical
No clonus observed
Sensory is intact

Strength:

left hip is 4/5 for flex/extension and 4-/5 abduction
left knee is 4/5 for flex/ext with pain in resited knee flexion
R hip and LE is 5/5 with MMT

Gait:
antalgic with note hip weakness in the abductors, left hip lacks extension.during gait.

Tests	Description	Results	Comments

ASSESSMENT:

Impression / Differentials: Left hip strain/injury from fall. Limited hip mobility and weakness. Left hip with signs of OA. X-rays negative. Bone scan may be appropriate if limite dprogress in therapy.

Therapy Problems
1. left hip pain with ambulaation and ADL function
2. left hip weakness
3. limited mobility of the left hip
4. STR/tenderness of the left hip

Goals:

Goal Term	Goal Description
1. Short-term	Decrease Pain
2.	Improve Soft Tissue Mobility
3.	Improve Joint Mobility - left hip and knee
4.	Improve Flexibility
5.	Tolerate Initiation of Strengthening Program
6. Long-term	AROM WFL without pain left hip
7.	LE MMT = 4+/5 for left hip and knee
8.	Zero to Trace Palpable Tenderness
9.	Zero to Trace Soft Tissue Restrictions
10.	ambulate for ADLs without pain.

TREATMENT PLAN: MT, TE, gait training, and modalities as needed

Consult with MD if minimal progress.

FREQUENCY & DURATION: 2 to 3 time(s) per week for 6 week(s).

Thank you for your referral!

Sincerely,

Ed Weber MPT

Edward G Weber MPT

Patient Name: Robert Marshall
Referring Physician: Lila Underwood NP

Dear Doctor,

1212 Garfield Avenue
Suite 200
Parkersburg, WV 26101

Mountain RIVER PHYSICAL THERAPY

304-865-6778
Fax: 304-865-7400

DAILY TREATMENT NOTE

Patient Name:	Robert Marshall	**Date:**	05-19-09
Patient ID #:	10266	**Time In:**	
Patient DOB:	05-08-1929	**Time Out:**	
Diagnosis:	719.45 Pain joint (arthralgia): pelvic region/thigh	**Referred By:**	Lila Underwood NP

SUBJECTIVE:

OBJECTIVE:

Treatments/Exercises	Results/Measurements	Minutes
1. Evaluation- Physical Therapy	1/	
2. Evaluation- Re Eval PT		
3. Electrical Stim- Unattended	1/ IFC lateral hip with MH	15
4. Manual Therapy		
5. Gait Training		
6. Therapeutic Exercises		

ASSESSMENT:

Goals:

Goal Term	Goal Description
1.	

PLAN:

Sincerely,

1212 Garfield Avenue
Suite 200
Parkersburg, WV 26101

Mountain River PHYSICAL THERAPY

304-865-6778
Fax: 304-865-7400

DAILY TREATMENT NOTE

Patient Name:	Robert Marshall	**Date:**	05-20-09
Patient ID #:	10266	**Time In:**	02:35PM
Patient DOB:	05-08-1929	**Time Out:**	03:50PM
Diagnosis:	719.45 Pain joint (arthralgia): pelvic region/thigh	**Referred By:**	Lila Underwood NP

SUBJECTIVE: No new changes since eval.

OBJECTIVE:

Treatments/Exercises	Results/Measurements	Minutes
1. Evaluation- Physical Therapy		
2. Evaluation- Re Eval PT		
3. Electrical Stim- Unattended	1/ IFC lateral hip with MH	15
4. Manual Therapy	1/ Gentle PROM left hip in abduction, flexion, ER/IR, side-lying quad/hip flexor stretch and STM lateral hip mm	20
5. Gait Training		
6. Therapeutic Exercises	2/	25
7. Nustep	8 min L1	
8. SAQ	3/10 bilaterally	
9. Active Heel Slide	3/10	
10. Hip abduction - hook lying	3/10	
11. GS	2/10 hold 5 sec	

ASSESSMENT: Initiated exercises as noted for strengthneing and mobility. Patient tolerated TE without c/o. Continues to be restricted in left hip mobility especially in IR.

Goals:

Goal Term	Goal Description
1.	

PLAN: Continue treatment plan.

Sincerely,

Ed Weber MPT

Edward G Weber MPT

1212 Garfield Avenue
Suite 200
Parkersburg, WV 26101

Mountain River PHYSICAL THERAPY

304-865-6778
Fax: 304-865-7400

DAILY TREATMENT NOTE

Patient Name:	Robert Marshall	**Date:**	05-22-09
Patient ID #:	10266	**Time In:**	11:00AM
Patient DOB:	05-08-1929	**Time Out:**	12:00PM
Diagnosis:	719.45 Pain joint (arthralgia): pelvic region/thigh	**Referred By:**	Lila Underwood NP

SUBJECTIVE: Patient reports doing fine after initiating exercises last treatment. He states he believes therapy is beginning to help his hip pain. No new c/o today.

OBJECTIVE:

Treatments/Exercises	Results/Measurements	Minutes
1. Evaluation- Physical Therapy		
2. Evaluation- Re Eval PT		
3. Electrical Stim- Unattended	1/ IFC lateral hip with MH	15
4. Manual Therapy		0
5. Gait Training		
6. Therapeutic Exercises	2/	30
7. Nustep	10 min L1	
8. SAQ	3/10 bilaterally	
9. Active Heel Slide	3/10 bilaterally	
10. *Hip abduction - hook lying*	3/10	
11. GS	3/10 hold 5 sec	

ASSESSMENT: Patient completed increased exercises without complaints. Patient reports feeling good after the ESTIM and MH today.

Goals:

Goal Term	Goal Description
1.	

PLAN: *Continue treatment plan.*

Sincerely,

Ed Weber MPT

Edward G Weber MPT

1212 Garfield Avenue
Suite 200
Parkersburg, WV 26101

Mountain River PHYSICAL THERAPY

304-865-6778
Fax: 304-865-7400

DAILY TREATMENT NOTE

Patient Name:	Robert Marshall	**Date:**	05-27-09
Patient ID #:	10266	**Time In:**	11:35AM
Patient DOB:	05-08-1929	**Time Out:**	12:35PM
Diagnosis:	719.45 Pain joint (arthralgia): pelvic region/thigh	**Referred By:**	Lila Underwood NP

SUBJECTIVE: Patient states noticing less pain at rest and less pain with walking. He still has pain in left hip when climbing into his truck.

OBJECTIVE:

Treatments/Exercises	Results/Measurements	Minutes
1. Evaluation- Physical Therapy		
2. Evaluation- Re Eval PT		
3. Electrical Stim- Unattended	1/ IFC lateral hip with MH	15
4. Manual Therapy	side-lying hip flexor/quad stretch - left	5
5. Gait Training		
6. Therapeutic Exercises	2/	30
7. Nustep	10 min L1	
8. SAQ	3/10 bilaterally	
9. Active Heel Slide	3/10 bilaterally	
10. Hip abduction - hook lying	3/10	
11. GS	3/10 hold 5 sec	

ASSESSMENT: TE as noted without difficulty. Patient continues to have tightness in the hip flexors.

Goals:

Goal Term	Goal Description
1.	

PLAN: Continue treatment plan and progress TE for hip/lumbar strengthening.

Sincerely,

Ed Weber MPT

Edward G Weber MPT

1212 Garfield Avenue
Suite 200
Parkersburg, WV 26101

Mountain River PHYSICAL THERAPY

304-865-6778
Fax: 304-865-7400

DAILY TREATMENT NOTE

Patient Name:	Robert Marshall	**Date:**	05-29-09
Patient ID #:	10266	**Time In:**	08:30AM
Patient DOB:	05-08-1929	**Time Out:**	09:27AM
Diagnosis:	719.45 Pain joint (arthralgia): pelvic region/thigh	**Referred By:**	Lila Underwood NP

SUBJECTIVE: Patient reports having minimal soreness in his hip today. He also reports doing good after last treatment.

OBJECTIVE: Patient refused the need for ESTIM today but he did want the MH. MH x 10 min left hip.

Treatments/Exercises	Results/Measurements	Minutes
1. Evaluation- Physical Therapy		
2. Evaluation- Re Eval PT		
3. Electrical Stim- Unattended		0
4. Manual Therapy	side-lying hip flexor/quad stretch - left	5
5. Gait Training		
6. Therapeutic Exercises	2/	37
7. Nustep	10 min L1	
8. SAQ	3/10 bilaterally	
9. Active Heel Slide	3/10 bilaterally	
10. Hip abduction - hook lying	3/10	
11. GS	3/10 hold 5 sec	

ASSESSMENT: Patient completed increased exercises without complaints, please see chart for details. Patient continues to have tightness in the hip flexors.

Goals:

Goal Term	Goal Description
1.	

PLAN: Continue treatment plan and progress TE for hip/lumbar strengthening.

Sincerely,

Stacy R Callow, MPT

Stacy R Callow MPT

1212 Garfield Avenue
Suite 200
Parkersburg, WV 26101

Mountain River PHYSICAL THERAPY

304-865-6778
Fax: 304-865-7400

DAILY TREATMENT NOTE

Patient Name:	Robert Marshall	**Date:**	06-02-09
Patient ID #:	10266	**Time In:**	08:01AM
Patient DOB:	05-08-1929	**Time Out:**	09:10AM
Diagnosis:	719.45 Pain joint (arthralgia): pelvic region/thigh	**Referred By:**	Lila Underwood NP

SUBJECTIVE: Pt reported minimal soreness today. He states being able to get into his truck without pain.

OBJECTIVE: Treatment ended with MH x 10 min to L hip.

Treatments/Exercises	Results/Measurements	Minutes
1. Evaluation- Physical Therapy		
2. Evaluation- Re Eval PT		
3. Electrical Stim- Unattended		0
4. Manual Therapy	1/ left ROM, side-lying hip flexor /quad stretches	10
5. Gait Training		
6. Therapeutic Exercises	3/	45
7. Nustep	10 min L1	
8. SAQ	3/10 bilaterally	
9. Active Heel Slide	3/10 bilaterally	
10. Hip abduction - hook lying	3/10 yellow	
11. GS	3/10 hold 5 sec	
12. Shuttle extension	2/10 bilateral, 1 red/1black	
13. Bridge	3/10	
14. Leg Press	2/10, 30 #	

ASSESSMENT: Patient completed increased exercises without discomfort. Patient continues to have tightness in the hip flexors.

Goals:

Goal Term	Goal Description
1.	

PLAN: Continue exercises and modalities as needed next visit.

Sincerely,

1212 Garfield Avenue
Suite 200
Parkersburg, WV 26101

Mountain River PHYSICAL THERAPY

304-865-6778
Fax: 304-865-7400

DAILY TREATMENT NOTE

Patient Name:	Robert Marshall	**Date:**	06-04-09
Patient ID #:	10266	**Time In:**	08:30AM
Patient DOB:	05-08-1929	**Time Out:**	09:50AM
Diagnosis:	719.45 Pain joint (arthralgia): pelvic region/thigh	**Referred By:**	Lila Underwood NP

SUBJECTIVE: Patient reports feeling better after last treatment. He states he continues to improve

OBJECTIVE:

Treatments/Exercises	Results/Measurements	Minutes
1. Evaluation- Physical Therapy		
2. Evaluation- Re Eval PT		
3. Electrical Stim- Unattended		0
4. Manual Therapy	1/ left hip PROM,in IR/ER, flexion, side-lying hip flexor /quad stretches	15
5. Gait Training		
6. Therapeutic Exercises	3/	45
7. Nustep	10 min L2	
8. SAQ	3/10 bilaterally 2#	
9. Active Heel Slide	3/10 bilaterally	
10. Hip abduction machine	2/10 30#	
11. GS	3/10 hold 5 sec	
12. Shuttle extension	2/10 bilateral, 1 red/1black	
13. Bridge	3/10	
14. Leg Press	3/10 30#	

ASSESSMENT: Patient completed increased exercises without complaints. Increased sets on the leg press and increased weight on SAQ. Patient reports feeling better after getting stretched.

Goals:

Goal Term	Goal Description
1.	

PLAN: Continue treatment next week.

Sincerely,

1212 Garfield Avenue
Suite 200
Parkersburg, WV 26101

Mountain River PHYSICAL THERAPY

304-865-6778
Fax: 304-865-7400

DAILY TREATMENT NOTE

Patient Name:	Robert Marshall	**Date:**	06-09-09
Patient ID #:	10266	**Time In:**	08:30AM
Patient DOB:	05-08-1929	**Time Out:**	09:40AM
Diagnosis:	719.45 Pain joint (arthralgia): pelvic region/thigh	**Referred By:**	Lila Underwood NP

SUBJECTIVE: Patient reports feeling good. He sttaes his hip continues to improve.

OBJECTIVE:

Treatments/Exercises	Results/Measurements	Minutes
1. Evaluation- Physical Therapy		
2. Evaluation- Re Eval PT		
3. Electrical Stim- Unattended		0
4. Manual Therapy	1/ left hip PROM,in IR/ER, flexion, side-lying hip flexor /quad stretches	15
5. Gait Training		
6. Therapeutic Exercises	3/	45
7. Nustep	10 min L3	
8. SAQ	3/10 bilaterally 2#	
9. Active Heel Slide	3/10 bilaterally	
10. Hip abduction machine	3/10 30#	
11. GS	3/10 hold 5 sec	
12. Shuttle extension	3/10 bilateral, 1 red/1black	
13. Bridge	3/10	
14. Leg Press	3/10 30#	

ASSESSMENT: Patient completed increased exercises without complaints. Increased sets on the leg press and increased weight on SAQ. Patient reports feeling better after getting stretched.

Goals:

Goal Term	Goal Description
1.	

PLAN: Re-assess next visit and likely plan for d/c.

Sincerely,

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Mountain River PHYSICAL THERAPY

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Fax: 304-865-7400

DAILY TREATMENT NOTE

Patient Name:	Robert Marshall	**Date:**	06-12-09
Patient ID #:	10266	**Time In:**	08:29AM
Patient DOB:	05-08-1929	**Time Out:**	09:25AM
Diagnosis:	719.45 Pain joint (arthralgia): pelvic region/thigh	**Referred By:**	Lila Underwood NP

SUBJECTIVE: Patient states no c/o. He reports that he no longer has hip pain with daily activitites. He does c/o occasional stiffness.

OBJECTIVE: HEP review. Assessment: strength is 4+/5 for flexion and abduction of the left hip and 4+/5 for knee extension. Hip mobility has improved for daily activities He continues to have some restriction in IR of the left hip but mobility appears equal to that of the right hip.

Treatments/Exercises	Results/Measurements	Minutes
1. Evaluation- Physical Therapy		
2. Evaluation- Re Eval PT	1/	
3. Electrical Stim- Unattended		0
4. Manual Therapy		
5. Gait Training		
6. Therapeutic Exercises	3/	45
7. Nustep	10 min L3	
8. SAQ	3/10 bilaterally 2#	
9. Active Heel Slide	3/10 bilaterally	
10. Hip abduction machine	3/10 30#	
11. GS	3/10 hold 5 sec	
12. Shuttle extension	3/10 bilateral, 1 red/1black	
13. Bridge	3/10	
14. Leg Press	3/10 30#	

ASSESSMENT: TE a snoted. Goals of treatment achieved at this time.

Goals:

Goal Term	Goal Description
1. Short-term	Decrease Pain
2.	Improve Soft Tissue Mobility
3.	Improve Joint Mobility - left hip and knee
4.	Improve Flexibility
5.	Tolerate Initiation of Strengthening Program
6. Long-term	AROM WFL without pain left hip
7.	LE MMT = 4+/5 for left hip and knee
8.	Zero to Trace Palpable Tenderness
9.	Zero to Trace Soft Tissue Restrictions
10.	1